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Adult Long Term Institutional Care

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REPORT OF THE SUB-COMMITTEE
ON SPECIAL SERVICES IN HOSPITALS

GUIDELINES FOR ESTABLISHING STANDARDS FOR

ADULT
LONG TERM INSTITUTIONAL CARE

Health Services Directorate
Health Services and Promotion Branch

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The information contained in these Guidelines was current at the time of publication. When using the Guidelines it should be remembered that certain aspects of the delivery of health care and health technology are changing rapidly. Should you identify any out-of-date material in the text, please inform:

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TABLE OF CONTENTS

		PAGE
GENERAL INTRODUCTION		vii
LIST OF PARTICIPANTS		x
PREAMBLE		1
GUIDELINES		
1.	POPULATION TO BE SERVED	5
2.	ASSESSMENT OF INDIVIDUAL CARE REQUIREMENTS	7
	2.1 Assessment process	8
	2.2 Assessment outcome	10
3.	TOTAL PLAN OF CARE	11
4.	BED AND SERVICE REQUIREMENTS	14
5.	ADMINISTRATIVE POLICIES, PROCEDURES AND CONTROL	19
	5.1 Purpose, Objectives and Goals	19
	5.2 The Governing Body	19
	5.3 By-Laws	20
	5.4 The Administrator	21
	5.5 Policies and Procedures	22
	5.6 Quality Assurance	25
	5.7 Financial Management	27
6.	STAFF ESTABLISHMENT AND COVERAGE	28
7.	STAFF TRAINING AND QUALIFICATIONS	30

PAGE

8. SERVICES AND PROGRAMS

Preamble 32

8.1 Medical and Dental Services 33
8.2 Nursing Services 37
8.3 Activities and Recreation 39
8.4 Diagnostic Support Services 42
8.5 Dietetic Services 43
8.6 Education Programs 48
8.7 Health Records 49
8.8 Infection Control 52
8.9 Occupational Therapy and Physiotherapy 53
8.10 Orthotics and Prosthetics 57
8.11 Palliative Care 58
8.12 Pharmacy Services 60
8.13 Psychology Services 65
8.14 Respiratory Technology 65
8.15 Safety 66
8.16 Social Work 67
8.17 Speech Pathology and Audiology 69
8.18 Spiritual Services 71
8.19 Support Services 72
8.20 Transportation 73
8.21 Volunteers 74

9. SPACE ALLOCATION, UTILIZATION AND SPECIAL DESIGN FEATURES

9.1 Exterior 77
9.2 Personal Space 78
9.3 Recreation and Activity Space 79
9.4 Dining Facilities 79
9.5 General Decor and Furnishings 80
9.6 Lighting 80
9.7 Colour 82
9.8 Sound Control 84

10. EMERGENCY PLANNING 85

PAGE

SELECTED REFERENCES 91

APPENDICES

APPENDIX I Types of Care 94

APPENDIX II Board Selection, Structure and Functions 97

APPENDIX III Orientation Programs 99

APPENDIX IV Guidelines for Policies and Procedures 103

APPENDIX V Examples of Policy and Procedure Manuals 108

APPENDIX VI Recreational Activities and Programs 112

APPENDIX VII Safety 115

APPENDIX VIII Transportation Services 122

APPENDIX IX Guidelines for Special Services in Hospitals 128

GENERAL INTRODUCTION

Background

Advances in health technology and changes in the planning and delivery of health care have contributed to an increasing demand for specialized care facilities and services in hospitals. A dramatic rise in the number of intensive and specialized care facilities and services in hospitals has occurred in recent decades due to rapid technological development in electronics and automation, and as a result of new approaches to patient care. These changes have produced demands for physical facilities, specialized equipment and highly-trained health manpower. Because of this, there is a continuing need of guidelines for standards to assist those involved in planning, organizing and operating special care services in hospitals.

Mandate

In 1972, health authorities in Canada recognized the need for guidance in this area, and the Federal-Provincial Advisory Committee on Health Insurance commissioned the Working Group on Special Services in Hospitals to create guidelines for standards to provide a reliable definition of requirements for a number of special care facilities and services.

Guidelines were developed by the Working Group for 14 units and services, and, in 1975, these were published under the title, "Guidelines for Special Care Units in Hospitals". This volume was widely distributed to provincial health and hospital authorities, and to national and international health organizations, and has been adopted by many as a guide.

The continuing development of existing and new health technologies, together with changes occurring in patterns of health care delivery, gave impetus to the updating of the 1975 Guidelines, and to the development of guidelines in additional areas. In 1982, the Federal-Provincial Advisory Committee on

Institutional and Medical Services (formerly the Federal-Provincial Advisory Committee on Health Insurance) granted the Working Group continuing status as a sub-committee of the Advisory Committee. The name of the Working Group was therefore changed to the Sub-Committee on Special Services in Hospitals. A complete list of Guidelines published or being prepared by the Sub-Committee is appended.

Methodology

The Guidelines published in 1975 were developed on the principle of a consensus of information, knowledge, experience and expert opinion obtained from appropriate organizations and individuals throughout Canada. They were based, where possible, on guidelines developed in Canada, and from authoritative sources in other countries. This approach has been generally acceptable to government and hospital authorities and the health professions.

The present Guidelines were prepared on a similar basis. On this occasion, in addition to input from provincial authorities, the expert opinion of health professionals was obtained through formally designated representatives of national health organizations representing the activities involved in each specific service. It is certain that many hundreds of health professionals from every area of the country have provided expert input in these Guidelines by this method, and have thus provided a truly Canadian consensus on these topics.

Suggested purpose of the Guidelines

The Guidelines should not be regarded as rigid standards. Their application may vary throughout Canada, and it is the prerogative of each province to accept, modify or reject the Guidelines according to provincial priorities.

The purpose of the Guidelines is to provide a definition of requirements for a number of special care facilities and services. They are not intended to provide standards for clinical practice.

Where development of a unit is under consideration, the Guidelines will assist planners and government health authorities in determining the need for such a unit, and in assessing the total potential impact of a new unit on existing and projected services, both at the local and regional levels. Deficiencies in existing services can be identified, and in some cases these can be corrected without the need to develop a new unit.

Where a unit already exists in a hospital, the Guidelines will help to identify problem areas related to administration, personnel, equipment, and physical facilities. They will help to determine necessary remedial action and to set priorities for corrective measures on the basis of clinical need, fiscal realities, and the degree to which a deficiency in the physical facilities impedes adequate functioning of the unit.

Future revisions

Because of the rapidly changing nature of health care, the Guidelines will require regular revision. it is planned to maintain the Sub-Committee to carry out this function.

Acknowledgments

The Sub-Committee acknowledges with sincere appreciation the immense amount of work undertaken and time given by practising health professionals in Canada in providing detailed written information and guidance in the preparation of these Guidelines. In addition, we wish to thank the many others who, in any way contributed advice and information to this endeavour.

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The working group acknowledges the significant contribution made to the development of the guidelines by many health care professionals, in particular Standards Officers of the Manitoba Health Services Commission, Mrs. Win Lindsay, Miss Anne Hrenchuk and Mrs. Janet Bjornson.

PREAMBLE

The following guidelines have been developed at the request of provincial health authorities to assist health care decision makers in managing health care resources, and also to assist those involved in the delivery of long term care to achieve high standards[1].

Population requiring long term care

Improvements in public health practices, new technological advances and a better understanding of the preventive, curative, social and rehabilitative aspects of health care have resulted in greater longevity for many Canadians. This has led to an increase in the number of persons requiring some form of long term care, whether it be services in the home or institutional care. The nature of this population and the key role that assessment plays in ensuring that the person receives appropriate services are addressed in the first two sections of these guidelines.

Types of care

Services and programs such as day care[2] and respite care often assist the individual to remain at home. In some cases a full assessment of individual needs and available resources indicates that the person is unable to live in a normal or adapted home setting and requires residential care in a long term care facility. This type of care may only be required for

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1 The guidelines are complementary to, and not intended to replace, The Guide to Accreditation of Long Term Care Centres, Canadian Council on Hospital Accreditation, June 1978.

2 Guidelines for Day Services will be developed at a later date. Geriatric support services have been partially addressed in Geriatric Day Hospital, Health Services Directorate, 1979.

a certain period of time and planning for discharge, however qualified, must be part of the total plan of care.

Various organizational arrangements exist in Canada for the provision of residential long term care and definitions of types and levels of care differ slightly from province to province. **In these guidelines Types II and III care, as defined in the Report of the Working Party on Patient Care Classification[3], are addressed. Basic requirements for both are the need for personal care on a continuing 24 hour basis with medical and nursing supervision and provision for meeting psycho-social needs. Persons requiring Type III care may also require a range of additional therapeutic services.**

Community Liaison and Coordination

Coordination and liaison with other health and social services in the community should be established. Joint planning with community care givers, the individual and the family in the assessment and placement processes will help to ensure that the person receives appropriate care. Provision of a continuum of care will reduce unnecessary institutionalization and will help to prevent the trauma of dislocation that occurs when a person is shuttled between different facilities and services.

The physical facility and the programs and services offered by the facility should be able to respond to the changing needs of the community that it serves.

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3 A complete description of the types of care can be found in Appendix I, pp. 94 to 96. Related provincial legislation, guidelines and standards should be adhered to when using these guidelines.

Quality of Life

Facilities for long term care are very different from acute care facilities. Throughout the following document it has been emphasized that the facility becomes the person's home whether the person is admitted for a short or lengthy stay. The quality of life is unique to the individual. Whether the person requiring continuing care is young or old, has a congenital or traumatic disability, or has reached this stage because of the aging process, each resident must be treated as a total person with a past, a present and future.

Essential aspects of the concept of quality of life include the need to preserve a sense of personal identity, the need to allow for privacy and independence, and the right to be treated with dignity and respect. Lack of privacy can lead to frustration, tension, withdrawal and/or acting out behaviour. The four basic states of privacy have been described as solitude, intimacy, anonymity and reserve. Staff and family must ensure that residents can experience these states of privacy as they wish. In addition, staff and family must also respect the privacy of each resident's body, personal belongings, personal physical space and environment.

Close attention must be paid to both verbal and non-verbal communication. Whatever degree of dependency is exhibited by the residents, they should always be treated with respect and addressed as adults. The need to reach out and touch, and be touched is an important communication mechanism and must be accommodated. The need to communicate by touch between residents or between a resident and spouse or friend must also be recognized and respected and appropriate privacy provided.

It is within the reach of every facility regardless of size, services or location to adopt a philosophy of care that makes provision for the concept of quality of life for the residents.

Definition of Long Term Care

"Long term care is that which is provided on an extended basis to meet the physical, emotional, social, spiritual and personal needs of persons whose functional capacities are chronically impaired or at risk of impairment.

It implies a holistic approach, which includes appropriate restorative, therapeutic, life enrichment and maintenance programs, the objective of which is to increase or maintain the health and well-being of the individual to his/her maximum potential."*

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* As defined by the Working Group.

GUIDELINES

1. POPULATION TO BE SERVED

In any given population a proportion of all age groups will require some form of long term care.[4] The elderly are the largest group of those who require long term care services. It is predicted that the increase in the numbers of the elderly, and especially of the very old, will escalate, and that by the year 2031, over 20 per cent of the population will be over 65 years of age. While the majority of these persons will not require institutional care, many will.

The Elderly

In planning for the care of the elderly it is more relevant to consider the biological, psychological and social needs of an individual rather than their date of birth or chronological age. However, persons of 75 years and over, who require long term care services tend to present particular needs due to their increasing vulnerability. Where effective services in the local community are in operation, many of these persons are able to remain at home. This has led to a resident population of the average long term care facility that is now generally older with more infirmity than a similar population five years ago. With this type of population the need for care services increases and there is also a greater requirement for psychiatric services because of the occurrence of mental disorders in addition to increasing frequency of physical disorders.

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[4] The population addressed in these guidelines is confined to the adult population i.e. 18 years and over. Companion guidelines for child and adolescent long term care are under development.

1.2 Younger Persons

Younger adults have special needs and a way of life that differ from those of older persons. The desire to conform to the behaviour of their own age groups will require special planning for activities that are popular with and appropriate for these younger people.[5] While ideally younger persons should be cared for separately some do inevitably find themselves in the same facility as the elderly. Where this occurs younger people should be accommodated in a special unit wherever possible, but in any case programs should be designed to meet their needs.

1.3 Mentally Dysfunctioning Adults [6]

These guidelines do not address the needs of persons in long-term psychiatric hospitals. However, within any long-term care facility some residents will experience emotional disturbances which may be episodic or may be of a more permanent nature. The severity of these problems ranges from mild disturbances, where there are symptoms such as simple confusion or mild depression, to severe disability such as dementia which may result in distressing, difficult to manage behaviours. Adequate assessment of these problems, as they arise, is essential in order to determine the cause of the behaviour and the factors contributing to the behaviour. Treatment of the emotional and/or medical condition, together with measures to promote reality orientation,

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[5] Because consideration of these needs is essential to the quality of life for younger persons, separate guidelines that address these topics will be developed.

[6] Companion guidelines for the long term care of mentally dysfunctioning adults will be developed at a later date.

arranged by staff who have access to expert advice in this area and who are aware of the fear and anxiety that can arise from these disturbances.

2. ASSESSMENT OF INDIVIDUAL CARE REQUIREMENTS [7]

Comprehensive assessment is the key to ensuring that individual needs are met. Professional examination and investigation of the person's physical, therapeutic, psycho-social and environmental status and needs should be carried out on an interdisciplinary basis. Organization of the assessment process may take many forms, but increasingly, special assessment units that serve a community or district are being established.

The assessment process must involve the individual and include information and observation from the person's family and other social supports. The impact on those persons who are currently caring for the individual must be assessed. In the elderly, the spouse is often experiencing a great deal of stress. Also children of the "very old" are often elderly themselves and find it difficult to care for aged parents.

Assessment is a continuing process. In addition to being used as a guide for ascertaining appropriate care, it should be carried out at regular intervals while the person is receiving care, and also whenever the person's condition warrants investigation.

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[7] Guidelines for assessment will be developed as a companion document.

2.1 Assessment Process [8]

Physical assessment

Reliable clinical information must be integrated into the assessment process. Physical examination should be carried out by a physician aware of the range of reversible causes of physical, mental and emotional dysfunction that can be corrected or modified with proper treatment.

The presentation of illness in old age is often misleadingly different from that in younger age groups and multiple medical problems may be present[9], the geriatrician can therefore make a valuable contribution to the assessment process for older persons. Education of health professionals who come into contact with the elderly can result in identification of treatable conditions that are often assumed to be part of the aging process. Assessment and treatment of physical problems may be all that is required to enable the person to resume their previous lifestyle.

Assessment of mental status

Emotional aspects of health status must be investigated as part of the total assessment. The interplay between physical and emotional health is well documented and particularly affects the older person who frequently suffers from several disorders.

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8 Additional detail concerning assessment of individual therapeutic, social and educational requirements is contained in the section on Services, and Programs, pp. 33 to 77.

9 Hodkinson, H.M.; Common Symptoms of Disease in the Elderly, Blackwell Scientific Publications, Oxford, 1976.

Depression often accompanies disabilities associated with chronic disorders, acute illness or a life change which results in a loss. The loss may be partial, as with decreasing vision or hearing, or may be complete as with a bereavement. Depression may be amenable to treatment.

Paranoid symptoms can be associated with changes in perception of the environment that can be caused by sensory impairment or by alterations in relationships with others; these symptoms may be relieved by various measures. Lifelong characteristics of personality or neurotic symptoms may be accentuated, and the typical style of coping may be less effective in the presence of physical illness or disability. The risk of suicide may be present and anxiety may be manifest in innumerable ways. In the elderly, dementia may be present, but is not an inevitable concomitant of aging. Cognitive impairment caused by strokes or Alzheimer's disease must be assessed.

Social assessment

Assessment of the individual's social environment helps to complete the picture of the person's ability to cope with normal activities of daily living. Assessment information would include aspects such as the person's financial status, educational needs, social needs, interests and hobbies and the degree of satisfaction with life experienced by the person.

Other considerations that may have a direct effect on the ability of the person to remain at home include family and other social supports, the availability and quality of support services in the community and the type and location of the person's residence. The availability of transportation services and/or inclement weather can affect accessibility to community services and other basic services such as medical services, food stores and recreational pursuits.

The attitude of the community at large, health care professionals and government policies towards individual needs will also directly affect assessment outcome.

2.2 Assessment Outcome

Following assessment, a course of action will be taken that may range from treatment at home to residential care in a long term care facility. The following list of possible assessment outcomes has been placed in alphabetical order and not in order of desired outcome. The list gives examples only and is not intended to be exhaustive.

- Acute care hospital
- Adult day hospital/day care
- Boarding home
- Community Support Services
- Co-ordinated Home Care program (short term/long term)
- Day activity program
- Discharge from a facility/program
- Geriatric assessment unit
  - day hospital
  - in-patient assessment unit
- Group home
- Long Term Care facility
- Medical treatment: own home

- Rehabilitation services

- Residential home with assistance available

- Respite care

While the outcome of the assessment process may result in a recommendation for various courses of action, including any of the above, the guidelines that follow apply specifically to the services of the residential long term care facility.

3. TOTAL CARE PLAN

3.1 General

A coordinated care plan should be developed for every person receiving long term care services. The care plan must be monitored on a regular basis to identify changing personal needs, to evaluate treatment outcomes and to update treatment requirements.

A care conference should be held where the plan for care on a day-to-day basis should be developed by the staff of the various disciplines involved in the care of the individual. The responsibilities of staff from each discipline should be outlined and the requirements for coordination of care identified together with treatment goals, therapies and expected outcomes. The plan should build on the strengths of each individual and should include individual and group activities designed to enable the person to maintain or reach his/her full potential while dealing realistically with the changing nature of disabilities.

The family should be actively involved with the resident in the planning and implementing of care.

3.2 Residential Care

The plan for residential care should make provision for the following additional factors:

Adaptation

When persons are admitted to a long term care facility they face a period of considerable adaptation, often when their physical and emotional resources are at their lowest ebb. The series of changes and losses experienced during a person's lifetime, particularly if the person is disabled, can culminate in a perceived loss of independence when they are admitted to a facility. They may be reluctant to risk developing new attachments because of the fear of further losses. In addition, for many persons lack of experience in communal living can lead to withdrawal and deterioration of their condition.

Residents must participate in planning for their own care whenever feasible and also be encouraged to contribute to decision making in the facility. This can give them a sense of control or direction in a situation where often helplessness and powerlessness can lead to a feeling of hopelessness, a triad that contributes to depression.

Appropriately trained staff and well designed facilities can help to reduce the negative aspects of institutional living and can assist residents in maintaining as satisfying a life style as possible.

Treatment[10]

Treatment and medication should be directed to the needs of the resident rather than those of the staff. In-dwelling catheters may ensure dry beds but should not be used unless all efforts to help a

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[10] Additional guidelines concerning treatment principles are contained in Section 8, Services and Programs, pp. 33 to 77.

resident regain control over bladder functioning have been exhausted. Tranquillizing medication can sometimes relieve a resident from distressing symptoms, however, it should never be prescribed to provide the staff with a resident population that is docile and easy to care for. While research and training are important components of long term care, it is necessary to ensure that residents are not overexposed to testing and questioning by students and researchers.

Continuity of care

Continuity of care and environment is important for the resident not only because of the long term nature of the care required, but also because of the problems of adaptation that can arise when a resident is moved from one facility to another.

Continuity of environment may help the resident to re-integrate after an episode of confusion or acute illness. Avoidance of contact with other residents during a period of disturbed behaviour may also avoid some of the apprehensiveness and change in attitude which can make continuing relationships difficult after the episode is over, and also perhaps reduce the need for modification of behaviour. Arrangements for continuity of care may require special facilities and management.

Coordination of care

A person should be identified to act as coordinator for the care plan. This person should have good interpersonal skills and the ability to work with the various disciplines involved in establishing the care plan. The coordinator should be given the necessary authority as well as the responsibility for the function. Because of the high incidence of medical disabilities and the twenty-four hour nature of care required, a nurse, who has knowledge of normal aging and disease in the elderly, and who has psychiatric training or experience, would be well equipped to fill this role.

Rehabilitation and discharge

The care plan should include an assessment of the person's potential for rehabilitation and discharge. Many residents, especially the elderly, will need continuing institutional care. There may be some residents who will require transfer to an alternate level of care.

The major step of discharge/transfer can be insurmountable unless a progressive plan is followed which involves the new potential care giver. This plan could include day, over-night and weekend passes, inclusion of the resident in day care programs, both associated with the institution and free standing, and possible temporary transfer to a Geriatric Unit. It is essential for provision of consistent care that the care givers involved in the discharge process share in detail the management plan used for the person.

4. BED AND SERVICE REQUIREMENTS

When planning for construction of an addition to a long term care facility, or for programs provided as an outreach service from the facility, it is essential that an analysis of community need and bed requirements be carried out. This will help to ensure rational use of resources while providing appropriate types and levels of care. Anyone who wishes to develop an adult long term care facility or plan for outreach services from an existing facility should liaise with the appropriate ministry when identifying a need or developing a proposal for a new facility. The approved capital planning and application processes will vary from province to province.

Throughout Canada, various methodologies and/or combinations of different methodologies are employed by the provinces and territories for determining and assessing need and to approve the type, size and placement of facilities. One of the most common methods used is the bed to population ratio or "fixed bed ratio" as it is sometimes called: the ratio of the

number of beds per 1000 population 65 years and older that have been shown to adequately serve an area in the past is used in planning for future needs. Often the key informant approach is used in early planning stages. A relatively simple survey is carried out which collects information from identified individuals such as medical officers of health, public health nurses, hospital administrators, and health planners, who have knowledge of the community, its people, their needs, and the services available to them. Some provinces or territories examine the length and reliability of waiting lists for admission to services and facilities.

There has been considerable debate over the ideal size of the long term care facility. The suggested optimal range of a free-standing facility would be from 75-150 beds. Variations are based on types and levels of care required, local needs and customs, urban/rural differences, and geographic location. Increasingly in Canada, individuals are requesting service in their own community. This has led to a demand for the development of smaller facilities.

4.1 Multi-level Care

In these guidelines, the population addressed has been generally confined to those requiring Types II and III care. This does not mean to imply that persons requiring these types of care should necessarily be segregated from others who require lesser amounts of care. Multi-level care ranging from senior citizens housing to Type III chronic in-patient care has been implemented in many locations[11]. The success of multi-level care, carried out in the same or adjoining facilities rather than different

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11 Multi-level care facilities: Evaluation of models for Alberta. Final Report Volume I. September 1981. Alberta Department of Hospitals and Medical Care, Alberta Housing Corporation, Woods Gordon Management Consultants.

levels of care being located in separate facilities, is dependent on many factors. Those contemplating taking the multi-level approach to long term care planning should be aware of both the advantages and disadvantages of this model.

Advantages include:

- a continuum of care which should lead to a reduction in relocation trauma;

- the maintenance of marital relationships when one spouse requires a different level of care than the other;

- the possibility of adjusting service levels to meet temporary changes in needs;

- economies of scale in basic and specialized services;

- efficiencies in providing support services;

- the potential for giving staff a change in work setting.

Disadvantages include:

- the risk of the resident becoming more dependent when a higher level of care is readily available;

- the possibility that the individual may withdraw from the community when essential services are available in the facility;

- the size of the complex could become very large and could take on the negative aspects of an institution rather than the positive aspects of a smaller home-like environment;

The following steps can be taken to overcome or minimize the disadvantages:

- selective implementation in only those communities and/or institutions which demonstrate strong, enduring support for the approach;

- tailoring programs to match local needs and resources;

- good planning and management;

- resident care classification system;

- encouraging maximum independency of residents, particularly those requiring lower levels of care;

- appropriate site selection and facility design.

4.2 Planning for the Physical Facility

Planning process

The planning process[12] includes the following stages:

- Proposal stage: proposed plan for solving an identified problem or need; submission of proposal to appropriate Ministry or Government Department;

- Design stage;

- Programming stage: accepted proposal transformed into a project plan;

- Construction stage;

- Evaluation stage.

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[12] Refer to Provincial guidelines for the planning process, for example Planning Process for Capital Projects, Alberta Hospitals and Medical Care, 1979.

Location and Site[13]

An architect and an engineer should be consulted when choosing a site to ensure that conservation matters, soil conditions, site-related opportunities and constraints are appropriately addressed. Flexibility for future growth according to projected need should also be considered.

Although many factors influence the choice between designing a single level facility and a multi-story facility, a single level is preferable for day-to-day programs and for ease of evacuation in the event of a fire or other emergencies.

The location of the long term care facility has a direct effect on the efficiency of operation and the quality of life for residents. The following factors should therefore be considered:

- Accessibility to professional services such as dentistry, optometry, and speech pathology if these services are not available in the facility;

- Reasonable proximity to an acute care hospital (particularly for a Type III care facility);

- Close proximity to a fire station;

- Ability to attract staff;

- Availability of good public transportation for staff, visitors and residents;

- Accessibility to public and commercial services such as stores and restaurants;

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[13] For information on space and design features, see Section 9, pp. 77 to 84.

5. ADMINISTRATIVE POLICIES, PROCEDURES AND CONTROL

5.1 Purpose, Objectives and Goals

The facility must have a clear, written statement of its purpose, objectives and goals which should be made known to staff, residents and their families, community agencies and other health care providers in the community. The goals and objectives should be reviewed on a regular basis, preferably annually, and amended as necessary to reflect the changing needs of the residents, the community and changes in the environment.

The purpose, objectives and goals must be operational and measurable with explicit targets and time frames, and must:

- meet the needs of the resident population;
- identify the relationship of the facility with other service providers in the community i.e. active treatment hospitals;
- be operational and measurable with explicit targets and time frames;
- include participation of residents and their families, staff and the community in their formulation as appropriate.

5.2 The Governing Body

In Canada, the sponsorship of long term care services may be either private proprietary organizations or public, non-profit corporations. Under such a pluralistic system, the governing body may be a corporation, government agency, partnership, religious, charitable or service organization, or an individual owner. The governing body is the ultimate authority in the institution and is responsible for the overall operation and management of the facility.

The establishment of a board is the most common arrangement found in long term care facilities.[14]

5.3 By-Laws

Each facility must have by-laws which conform to federal, provincial and municipal statutes. By-laws are regulations which describe the structural and procedural mechanism which the Board has established to direct the operation of the facility. The by-laws and their contents will vary from facility to facility, but should in every instance define the rules for the general and medical administration of the organization.

The by-laws pertaining to general administration should include, but not be limited to:

- the purpose, goals and objectives of the facility;
- composition, method of selection and term of appointment of the Board of Directors;
- responsibilities and duties of the officers;
- a definition of the signing officers;
- the membership, mandate and reporting relationship of the committees of the board;
- the requirement for the appointment and authority of an auditor;
- the appointment and duties of the administrator.

Health Care Provider/Administration

Policies, and where applicable by-laws, should be established governing arrangements for the provision

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[14] See Appendix II, pp. 97 to 98 for details on board selection structure and functions, and Appendix III, p. 99 on orientation for board members.

of medical and other health care services by providers, whether institution employees or not.

Policies should be made for:

- establishing arrangements for the provision of the services;
- establishing the professional rights and responsibilities of providers;
- establishing the credentials and status of the providers;
- setting out type and scope of practice;
- rules and regulations of practice;
- maintenance of resident care records;
- frequency of provider attendances with the resident;
- assurance of availability of emergency services;
- assurance of quality of care;
- authority of designated consultants and advisors.

5.4 The Administrator

The administrator is responsible for the overall operational and financial management of the facility. He/she attends or is represented at all board meetings and provides information and advice to the board regarding policy, program and personnel requirements. Where appropriate, the administrator may also serve as a member of board committees. The administrator evaluates managerial staff, current programs and the overall effectiveness of the facility, maintains good working relationships with community agencies and professional associations and also responds to inquiries concerns and/or complaints of residents and/or their relatives and others.

In addition to the staff attitudes and skills outlined in section 7.1 page 30, the administrator should have held positions with progressive administrative responsibilities and have demonstrated leadership and management abilities. These would include organizational and strong interpersonal skills, problem-solving abilities and excellent verbal and written abilities.

Educational requirements include as a minimum the Canadian Hospital Association's "Long Term Care Organization and Management" course. An accredited university degree in health service administration or business administration is increasingly becoming a requirement for this position. Membership in appropriate long term care associations and interest groups are also assets.

5.5 Policies and Procedures [15,16]

Every facility should develop policies and procedures that are designed to achieve the purpose and objectives and goals of the organization. All policies and procedures should be approved by the governing authority and/or administration. Policies are stated general plans of action; procedures are the specific steps required to carry out these plans of action.

The initial development should allow for changes and regular review and update on a systematic basis. Policies and procedures should be available to the staff in the form of a printed manual. The manual serves to identify organizational structure, promotes clarity, consistency, continuity and adequacy of performance, provides key information for orientation and training and acts as a consistent reference for ongoing activities.

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15 See also Appendix IV, pp. 103 to 107.

16 For assistance in developing a policy and procedure manual see: Cryderman, Paula, Developing Policy and Procedure Manuals, 1981.

There are two distinct types of policy and procedure manuals. The administrative manual contains overall policies which give direction to managers for the day-to-day activities of the organization as a whole. The departmental manual governs the operation of a particular service. These manuals may be consolidated into a single manual, depending on the needs of the facility.

Details and examples of each type of manual and relevant policies and procedures for long term care are outlined in Appendix IV, pp. 108 to 111.

In the following sections, policies for issues that are often problematic in the long term care facility are addressed in more detail.

5.5.1 Restraints

The use of restraints should be avoided wherever possible and policies relevant to their use must be developed by the governing body of the facility and should conform to provincial laws and regulations. A physician's order should be required for the use of restraints and the order should be valid for a limited time period, e.g. 24 hours. Current concern over the use of restraints in long term care facilities has led to research studies in this area.[17]

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17 Mitchell-Pedersen et al. have shown that the use of physical restraint can be virtually eliminated from in-patient geriatric services without either consequent increase in harmful injuries or increase in pharmacological restraint.

See also Powell, C., and Fingerote E., "Freedom from restraint: Consequences of reducing physical restraints in the treatment of elderly persons", Annals RCPSC, Vol. 16, No. 4, June 1983, p. 343.

5.5.2 Guardianship[18]

Guardianship refers to a legally recognized relationship between a specified competent adult and a dependent adult. The dependent adult is a person who has a significant degree of mental disability affecting his/her person. The capacity is, therefore, vested in the guardian to be exercised in the best interests of the dependent adult. The court may appoint the competent adult with respect to any or all of the dependent adult's physical (medical), mental, social, vocational, residential, educational and other personal needs (other than financial)[19], both present and future.

Procedure

The resident's ability to make appropriate decisions in regard to personal, physical, medical, social, vocational, residential, educational and other personal needs, (other than financial) should be reviewed with appropriate members of the care team and family. If the resident is found to be incapacitated mentally, interested relatives should contact a private solicitor and initiate a guardianship procedure. If there is not an interested relative, the institution involved can initiate an application for a public guardian, particularly to have the area of medical consent addressed.

5.5.3 Short term intercurrent illness

Policies regarding the provision of care for residents with short term intercurrent illness may be established. The interests of the residents would best be served by providing this care within the facility.

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[18] Refer to provincial legislation for local rules and regulations.

[19] See page 28 for information on financial management.

Transferring the resident to an acute care general hospital may create problems of adaptation. Strange surroundings and unfamiliar staff, in addition to the worry of losing his/her bed at the long term care facility, may lead to complications of the illness, particularly in the frail elderly.

Policies should be established, in accordance with provincial regulations, to cover the following areas:

- Identification of person(s) who is responsible for deciding whether the resident stays in the facility or is transferred;

- Definition of allowable changes in staffing patterns to accommodate the resident's needs;

- Identification of beds, space, and allowable movement of beds to meet specific patient needs, e.g. placing the resident close to the nursing station;

- Whether the family/resident should be given the option of assisting in care, e.g. hiring a private duty nurse on a temporary basis.

5.6 Quality Assurance

Quality Assurance describes the collective activities that are carried out to assure the quality of resident care. A quality assurance program should provide the information needed to evaluate resident care, improve existing programs, develop necessary new programs, improve staff knowledge and skills and to make the best use of resources. An effective program can assist in identifying gaps or weaknesses in the provision of care and can identify education needs. It can also help to ensure compliance with standards and regulations, improve staff documentation of care, and improve staff and resident morale.

An essential element of quality assurance is auditing care, and every facility, regardless of size, should

have an audit committee. Each professional discipline may undertake an appraisal or audit of its own work but preferably the appraisal should be undertaken by a multidisciplinary team which looks at the care as a whole.

The team members together should establish objectives or criteria which should be clear cut, measurable, desirable, and time related. These criteria should relate to the specific types of residents such as persons with similar problems.

The audit is comprised of three components:

- the structural audit where management and staff evaluate the organizational structure, resources and environment of a program;

- the process audit where processes of care are reviewed;

- the outcome audit which analyses the results of care given.

The audit may be carried out in different ways including a concurrent audit which is observation of the ongoing care given in relation to resident's needs as well as a review of the resident's records. A retrospective audit appraises the stated care given as it is recorded in resident care records. A departmental audit identifies strengths and weaknesses of current policies and procedures, legal issues and documentation.

Existing committees and activities can form a part of a quality assurance program. They may include reviewing and evaluation of medical and dental credentials and procedures performed; morbidity and mortality in the facility; health records recording; resident care; safety; infection control; incidents; pharmacy services, and employee performance.

Other activities include establishing admission criteria; involving the resident and family where possible; and ensuring that there is a current, relevant care plan for each resident.

The key to the effectiveness of a quality assurance program for long term care is the participation of the providers of care in the committees which play important roles in the process.

5.7 Financial Management

Operating Budget

An operating budget is a management tool which has been developed in relation to the revenues and expenditures normally associated with the day to day operation of the facility. Regardless of the size of the facility, an operating budget is essential as it is a way of exercising control on the financial operations.

For most facilities, the Chief Executive Officer or Administrator is responsible to the Board of Directors or owner for the financial operations of the facility. In developing a budget, the administrator may delegate the authority and responsibility to a staff member with the necessary financial expertise. All members of the organization should be aware of the purpose of a budget, i.e. to act as a planning and management control mechanism.

When preparing the budget, several factors must be taken into account. These include the Board's program, planning and financial priorities and constraints for the year. In addition, the purpose of and desired information required from the budget must be determined. The budget should be prepared with departmental or service input, where the departmental or service heads are held accountable for expenditures during the actual operating year.

Capital Budget

In addition to the operating budget, a capital budget must be developed on an annual basis to ensure that cash outlays for fixed assets such as equipment replacement and improvement or additions to the physical plant are based on a carefully planned program. Capital requests should be priorized as capital funding is often limited. A three to five year capital budget plan should be integrated into a long range plan for the acquisition and disposal of capital equipment as well as for maintenance and renovation to the physical plant.

External Audit

Each facility must retain the services of an external auditor to review the internal financial control system within the organization. This is to ensure that the accounting records are reliable and sufficient as a basis for the preparation of the financial statement and that financial information is adequately disclosed in the financial statements.

Personal Finances of Residents

Policies and procedures designed to protect personal financial interests of residents must be carefully established in conjunction with the legal counsel of the facility, the auditors, and where appropriate the residents' own legal representative. Assessment of residents' competence to manage their own business affairs must comply with the relevant provincial health acts. Legal advice should be sought when situations arise such as granting of the Power of Attorney or Trusteeship.

6. STAFF ESTABLISHMENT AND COVERAGE

Where provincial staffing requirements for long term care facilities exist, they should be applied when estimating the numbers and types of staff that will be required.

As stated in preamble:

- A Type II care facility will need staff to provide personal care on a continuing 24-hour basis with medical and nursing supervision and provision for meeting psycho-social needs.

- A Type III facility will need staff to provide a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. Additional information on staffing requirements is contained in each of the services outlined on pages 33 to 77.

The numbers and types of staff required for safe care and treatment of mentally dysfunctioning residents will depend on the numbers of these residents, the training and qualifications of available staff, and the physical design of the facility. When a resident is agitated, there is a greater need for close supervision by staff. Proper handling by a trained person can do much to reduce the agitation.

6.1 Orientation

An orientation program[20] should be established at the general level for staff who are new to the facility and also at departmental level for staff who are new to a department. This program assists new employees to become familiar with their job responsibilities and also with the philosophy and objectives, policies and procedures, services, other staff and residents of the facility. Management and supervisory staff must be committed to the development and delivery of the program.

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20 Components of this program are outlined in Appendix III, pp. 99 to 100.

7. STAFF TRAINING AND QUALIFICATIONS

7.1 General

Because of the long term nature of the resident's stay, many categories of staff have a direct relationship with the resident. Staff should be selected who have an interest in, and understanding of, the special needs of elderly and handicapped persons, and who respect the dignity and worth of the individual. Staff must be able to work effectively as a member of a team that is committed to carrying out the requirements of the resident's total plan of care.

7.2 Initial Training

Training requirements for many disciplines are stated in the services outlined on pages 33 to 77. However, as previously stated, by-laws should provide for establishing the required credentials and status of the providers of care. (See p. 21)

7.2.1 Supervisory and Leadership Positions

In the long term care facility, there is a relatively higher proportion of non-professional staff to professional staff than in active treatment hospitals. This requires a greater degree of leadership on the part of professional staff in most positions. In selecting staff for supervisory or leadership positions, the following additional factors should be considered:

- Successful completion of management training courses;
- Leadership and supervisory experience;
- Attitudes to the leadership roles.

7.2.2 On-the-Job Training

It is the responsibility of department heads (in conjunction with the Personnel Department where appropriate) to design and provide on-the-job training for employees who do not require special qualifications to do their jobs. Essential elements of an on-the-job training program include the details of "how to do" each task the employee is expected to perform in the course of his/her job. While it is recognized that the "buddy" system of learning has a role, each new employee must be taught by an authorized person.

7.3 Continuing Education [21]

7.3.1 Staff Development Program

A staff development program with a budget allocation should be planned and carried out. Components of the program should include in-service education, encouragement of staff to attend appropriate educational workshops and programs in the field, provision of resource and reference materials, and an employee performance review and appraisal program. An effective staff development program will help staff to achieve personal and professional growth and development and can help retain employees who have demonstrated potential for additional responsibilities but who lack the requisite knowledge and skills.

7.3.2 In-Service Education Program

The in-service education program should be designed and structured to meet the initial and on-going needs of all staff. The program should be directed by a staff member qualified by experience and education. Objectives, content and evaluation techniques should be identified. All personnel should be

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[21] For additional information on Education Programs, please see pp. 48 to 49.

encouraged to contribute ideas to be used in selections of program content.

7.3.3 Employee Performance Review and Appraisal Program

The performance of all employees should be reviewed and appraised on a regular basis. This process helps to assess performance strengths and weaknesses, to determine training and education needs, and to identify career aspirations and potential for advancement. The provision of this type of ongoing feedback also helps to improve communication between supervisor and staff member. An appeal mechanism should be available to the employee who is not satisfied with the appraisal.

7.3.4 Students

Students from different disciplines may receive part of their training in the long term care facility. In order that they can benefit from this valuable experience, they should be accepted into the day-to-day life of the facility. Because of the long term nature of relationships between residents and permanent staff this may not always be easy to accomplish. However, it should be remembered that new faces and ideas can be stimulating to the residents. Students should be included in the orientation program. They must be taught and supervised by an authorized person. Affiliation arrangements should exist between the long term facility and the sponsoring educational institutions.

8. SERVICES AND PROGRAMS

The thrust of long term care services and programs should be towards the promotion of health and independence and the prevention of disease and physical and mental disability. The decision regarding which services and programs will be required by the indi-

vidual must be based on the results of a coordinated assessment.[22]

In the following section a broad range of services and programs are described. Some of the services and programs, such as nursing services, will be offered in both Types II and III care facilities. Others, such as physiotherapy, may be part of the range of therapeutic services offered only in facilities providing Type III care. In some areas the services may be required and/or available on a part-time basis. For example, a speech therapist may spend one day a week at the facility. In other areas, the resident may be taken to a larger centre for services, such as diagnostic services, that are needed on a short-term basis.

The range of services and programs offered in a particular facility will depend on many factors such as government policies, funding mechanisms, local need and policies of the facility. During the placement process a facility should be chosen that can meet as many of the person's needs as possible.

Activities and recreation, social activities and customs which were part of the resident's lifestyle before admission should be encouraged to continue as long as possible, and preferably should include the spouse and/or other members of the family.

In the following guidelines for services and programs, medical and nursing services are addressed first and other services are listed alphabetically and not in order of priority.

8.1 Medical and Dental Services

Recommended treatment arising from the assessment process[22] must be started as soon as possible. This

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[22] See Section II, pp. 7 to 10.

will ensure that reversible causes of physical, mental and emotional dysfunction can be corrected and may enable the disabled person to be maintained appropriately at home.

The physician should be part of the interdisciplinary team that carried out the assessment as he/she is often the only constant health care worker in the disabled person's group of supporters. If there is doubt about the diagnosis or prognosis a more sophisticated assessment may be required. For example, assessment of the elderly person by a local Geriatric Service may lead to diagnosis and treatment as an outpatient which could be cost effective in addition to being therapeutic and may delay the need for residential care in a facility.

If the assessment process is carried out as recommended then it is presumed that the admitting facility is accepting only those persons who truly need to be admitted. Some residents will be admitted because care in a facility can reverse the decline which they face if an unrealistic struggle for independence continues too long.

Continuing Care of Residents

Following admission, each resident should be under the care of a named physician. Often this will be the residents' family physician, but factors such as Board policy, distance from the physician's office, or the ability of the physician to visit the institution on a regular basis may make the transfer of the resident to another physician's care preferable. Where this occurs, residents and their families should have a choice of physician.

Attending physicians in large urban areas should be encouraged to care for residents only in a few facilities so that they can visit more easily. Physicians' visits should be on a regular basis and at appropriate times, normally on a weekday, so that consultation can take place with the regular nursing

staff, and other staff who are providing services to the resident.

Physicians must provide or arrange for emergency coverage when necessary. Long term care residents should have ready access to specialist medical services such as psychiatry, physiatry, surgery, ophthalmology and otolaryngology when required. Some services will need to be brought to the institution because of the increased immobility of some residents.

Some specialist services may be required on a more regular basis than others. Physicians of accepted ability in geriatric medicine and consultants who are experienced in psychiatry and geriatrics in particular, can make a valuable contribution to the care of elderly residents. These physicians should be encouraged to provide consultation services to the facility and also to act as a resource to staff. Employment of these physicians on a sessional basis allows for activities in addition to medical consultation services, including liasion aspects, in-service education for staff, and case-finding and research where appropriate.

A geriatrician or a group of interested physicians should also provide advice and opinion to administration to assist in developing facility care policies. Input into policy formation and procedure performance would be in areas such as the quality of medical care, infection control and emergencies or accidents.

Physical Facilities

An examination to diagnose a resident's illness is often difficult or incomplete when carried out by the physician in the resident's bedroom. An examination and treatment room is therefore required which should have as a minimum; good lighting, an examination couch at appropriate height for the disabled and basic instruments to conduct the examination and to perform simple medical/nursing tasks such as ear

washouts, vaginal examinations, wound dressings, eye examinations and foot care.

8.1.1 Dental Services

The oral health of residents can be affected by many factors. Poor psychomotor ability can reduce a person's ability to perform oral hygiene. Inadequate nutrition, and conditions such as cardiovascular, circulatory and arthritic ailments can be contributing factors to oral health problems. Loss of teeth, poorly fitting dentures and a decreased ability to chew can result in low self-esteem and poor nutritional intake.

Assessment of oral health status should be part of the initial assessment process. Examination, treatment, instruction in care and periodic recall should be carried out by a licensed dentist. A daily oral health care plan should be developed as part of the total plan of care and should include education on prevention and care. Staff should regularly monitor the residents' ability to perform oral hygiene and give assistance where necessary. In-service training for staff should include an oral health component. Professionals involved in resident care such as medical and nursing staff, social workers and nutritionists must be encouraged to report information regarding dental problems of residents. Dental services may be carried out by dentists attending the facility, or by dentists practicing in private offices. The dentists involved should be granted practicing privileges by management, particularly if the services are provided within a hospital. Consultation with medical doctors and families is important so they are kept abreast of any need for referral of patients.

Where there is an in-house service, the equipment requirements for dental services may include a dental chair (pump or electric), a mobile light, and an X-ray unit. This basic equipment will enable the practitioner to examine and survey patients who

cannot attend clinics. Examinations, taking radiographs, and carrying out various phases of prosthetic dentistry should be performed. Because of multi-medical problems of some residents, it is important to have a fully equipped resource to handle any medical emergencies that may arise. Treatment for periodontal problems, surgery and restorative dentistry should be referred to outside specialists in these areas.

8.2 Nursing Services

The nature of the relationship between the nurse and the long term care resident is one of intimate daily contact between the two which enables the nurse to know and understand the needs of the resident. The nurse is therefore in a good position to help the resident to achieve a balance between having as satisfying a lifestyle as possible while coping realistically with illness, disability and/or aging.

Because of the day-to-day contact with the resident and the family the nurse can ensure their input into the total care plan and/or can act as their representative when necessary. As previously stated a nurse with appropriate education and experience is able to coordinate the total plan of care.[23]

Organization

The philosophy and objectives of the nursing services should reflect those of the individual facility and should be in keeping with accepted standards of nursing practice. The primary purpose of the service is to assess, plan, implement and evaluate the care of the residents. For the purpose of this document, the nursing service consists of all categories of nursing personnel employed by the facility to provide nursing services and other care for the residents.

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[23] See p. 13.

Staffing

Because the nursing service is the basic component in the planning, delivery and evaluation of care in a long term care facility, the attitudes and beliefs of the nursing staff have a direct impact on the quality of care provided. The guidelines in the section on staff training and qualifications must be considered in recruiting and maintaining an adequate and competent staff.[24]

Staffing needs may be based on a resident classification system suitable for the size and type of facility and/or on provincial guidelines. Whatever system is used it should include elements dealing with the total needs of the residents. The staffing mix and schedules should reflect the level and number of nursing personnel needed to meet resident nursing care needs. Consideration should be given to employing an appropriate ethno-cultural staff mix.

The nursing services should be under a director of nursing who should be a member of the senior administrative staff of the facility. The director of nursing is responsible for maintenance of nursing standards and recruitment of nursing personnel.

He/she provides for efficient organization, management and staffing, for ensuring the quality of nursing care and the continuing education of nursing personnel. The director must be currently registered in the province where he/she is employed and should preferably have a baccalaureate degree in nursing. A minimum of three years recent experience in nursing and especially long term care nursing is necessary with at least one year of management and knowledge of current standards for nursing practice and the nursing process.

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[24] See pp. 30 to 32.

Registered nurses are responsible to the director of nursing and work closely with the director and other members of the health care team. They may provide direct nursing care and/or supervise care given by others. There must be at least one registered nurse on duty in the facility at all times. Registered nurses must hold current registration in the province where they are employed and should have knowledge of current standards of nursing practice and the nursing process and experience in long term care.

Qualified nursing assistants provide nursing care as part of the interdisciplinary team under the direction of the registered nurse or director of nursing and may supervise care given by other nursing personnel. They should hold current registration or licensing in the province in which they are employed and preferably be experienced in long term care.

Nursing aides provide personal care under the supervision of a registered or qualified nursing staff member. Completion of a certified health care aide course and experience in long term care is desirable. If nursing aides are recruited without previous training, appropriate "on the job" training must be provided.[25]

8.3 Activities and recreation

Activities and recreational pursuits should be based on the needs of residents to maintain or increase their physical, intellectual, emotional and social abilities. When successfully implemented, activities and recreational programs can help the resident gain a sense of achievement, exhilaration, acceptance, success, personal worth, pleasure and a positive self-image.

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[25] See Section 7.2.2, p. 31.

Organization

The program should be under the direction of an activity coordinator with assistants as deemed appropriate and necessary according to:

- the numbers of residents;
- the functional levels identified and individual needs of residents;
- the types of activities required to meet these needs;
- the availability of trained volunteer input.

Consultant services should be used when required. Such services would normally include: Physiotherapy, Occupational Therapy, Music Therapy and Library Services.

Staffing

The co-ordinator should be a recreation specialist or a person with a similar background. In addition to the general requirements for all staff, this person should have a knowledge of psychology and sociology of human behaviour and a demonstrated ability to develop activities and coordinate resources to meet the special needs of individual residents.

Programs

During the assessment process and development of the care plan, activity and recreational needs will be identified and planned for with the resident and, where appropriate, the family.

The type of activity and recreational pursuits chosen will be based on:

a) the expressed preferences of the person;

b) consideration of the person's:

- cultural background;
- degree of social interaction (individual and group);
- level of emotional adjustment;
- mood, self-esteem;
- behavioural aspects;
- leisure interests and restrictions.

Assessment should be carried out on a regular basis to ensure that the resident's needs and wishes are being met.

While activities[26] will be based on the needs of the residents to maintain or increase their intellectual, emotional and social abilities, programs will need to be designed to create opportunities for individual, small, large and mass group activities. Interaction of therapeutic programs, such as reality orientation, remotivation and validation, with activity programs is essential in order to ensure continuity of care.

Activities can be centered around special occasions such as birthdays, seasonal events such as a spring festival and theme oriented celebrations such as a country and western musical festival.

Family and volunteer involvement

As in many other aspects of life in the facility, involvement of family members and volunteers[27] in

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26 See Appendix VI, pp. 112 to 114 for a sample list of possible activities.

27 See also Section 8.21 on Volunteer programs, pp. 74 to 77.

activities and recreation programs can bring an element of the community to the resident.

Space requirement[28]

A multi-purpose room with adequate storage and mobile partitions should be designed to allow for the numbers of residents to be served and for the varied large and small group activities. A kitchen area is also needed which should be accessible to wheelchair patients.

Space for outdoor activities will be required that is accessible and safe for all residents including those who are disoriented.

Equipment

Requirements for equipment will depend on the types of activities provided for individual resident needs.

8.4 Diagnostic Support Services

Residents should be able to receive the diagnostic services which their conditions require in such a way that they will be least traumatized by them. These diagnostic services mainly include laboratory services and diagnostic services such as radiology, nuclear medicine, computed tomography, diagnostic ultrasound and electrocardiograms.

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28 In addition, see general guidelines for personal, recreational and activity space Section 9.2 and 9.3, pp. 78 to 79.

See also Space Programming Methodology, Health Facilities Design Division, Department of National Health and Welfare. (Although these guidelines are designed for the active treatment setting, some principles will also apply to the long term care facility).

These services are not normally located in the long term care facility. Delivery of the services may take one of two forms:

- the use of portable equipment that is brought to the facility;

- obtaining services from an outside source e.g. sending specimens to a laboratory; sending the resident to an acute care hospital, private laboratory or other facility that offers these services.

Personnel carrying out these services must be qualified and must operate within the provincial and federal legislation governing these services. All specialized equipment used must be inspected, tested and monitored in accordance with the standards set by the various federal, provincial or professional authorities. This equipment must be installed in safe locations in accordance with the relevant safety regulations. Guidelines for use of these services and techniques for collection and disposal of samples for analysis must be explicit and clear.

Reports on resident tests and examinations should be available within a reasonable time.

8.5 Dietetic Services [29]

Dietetic services and nutrition are key factors in the maintenance of the resident's well-being.

The purpose of the dietetic department is to provide a food service which will assist in the improvement of health and/or maintain optimum health and satisfaction of the resident.

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29 For comprehensive coverage of dietary services in general, refer to: Dietetic Department Guidelines in Smaller Health Care Facilities, 1981 Health Services Directorate, Department of National Health and Welfare, Ottawa, Ontario.

The objectives of the department should be to provide nourishing food that is pleasing to the residents and meets their nutritional needs, in the right quantity, and of high quality in an environment which will make mealtime a pleasurable experience.

8.5.1 Organization

Planning for individual needs

- A written dietary plan is required for each resident, prepared with resident input, as part of the total plan of care. The plan should include consideration of residents' likes and dislikes, portion sizes, ethno-cultural tastes and physician's orders.

- Regular interaction between dietary staff and resident is necessary.

- The dietary plan should be assessed at regular intervals, also as requested by resident and as requested by staff. Regular monitoring and recording of the food intake of residents is required to ensure nutritional needs are met and that meals are pleasing to the resident.

- Therapeutic diet orders must be frequently reviewed with medical staff.

- Use of selective menus or cafeteria style food service where individuals can make their own choices is desirable. Careful monitoring is needed to ensure nutritional needs are met.

Timing

- Timing of meals and snacks should coincide with normal eating times of the majority of residents and of the local community where appropriate.

- No more than fourteen hours should elapse between the evening meal and breakfast.

- Flexibility in serving times e.g. choice of different sittings, helps to preserve freedom of choice for residents.

Menu planning

- Four to six week cycle menus which follow Canada's Food guide are recommended.

- Menus should be changed seasonally to assist in cost and inventory control and help avoid the monotony of shorter term menus.

- While most residents prefer old favourites, new foods introduced occasionally will help avoid monotony and provide needed changes in routine.

- Every special occasion should be used as an opportunity to celebrate by providing appropriate food on the day.

- Snacks are often regarded by residents as a highlight of the day. Careful planning is needed to ensure that energy intake and nutritient density of daily food intake is balanced.

- For therapeutic diets, use of a diet manual authorized by medical staff will assist in providing consistency in the diet prescription and provision of allowed foods.

Staffing

The services of a registered dietitian or nutritionist should be available, either on a consulting, part-time or shared service basis depending on the size of the facility. The person in charge of the department should have training and experience in long term care as problems, situations and approaches are unique to this setting.

Adequate staff must be employed and their hours of coverage should be scheduled to best meet the needs of the resident.

Education programs included as part of the regular routine and readily available reference material will assist staff to practise the principles of safe food handling and sanitation and will improve their knowledge of nutrition as well as other aspects of the food service.

8.5.2 Food preparation and handling

The senses of taste and smell are thought to be less acute in later life. Whenever possible food should be of normal consistency and should only be ground or blended if the resident's condition demands this. Meals should be attractive, served at appropriate temperatures and be properly seasoned. Standard recipes should be used in order to ensure consistency and to help effect cost control.

Infection control procedures and safe food handling techniques should be practised at all times.[30] Worn chipped china or china that has lost its glaze should never be used.

8.5.3 Food and drug interaction

Considerable information is now available on food and drug interaction. Just as some foods can affect the way drugs behave in the body, so some drugs can affect the way the body uses food. Nutrient depletion occurs gradually, and persons taking drugs over long periods of time should be monitored as food and drug interactions can lead to deficiencies, particularly in children, the elderly, those with poor diets and the chronically ill.

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[30] See section on Infection Control, pp. 52 to 53 and references to food handling, p. 89.

8.5.4 Place settings and mealtimes[31]

Place settings should be attractive and mismatched china should be avoided. A permanent assortment of condiments on the dining room tables detract from the attractiveness of the table setting. Appropriate cutlery and other eating aids for disabled persons should be provided. Before these adaptive aids are supplied it is preferable to investigate if a regular type china and cutlery could be used. Before purchasing china, the weight and design need special consideration; for instance, the weight of the cup and the design of the handle affect control of the cup by the resident.

The mealtime experience should be positive. Every effort should be made to ensure that table mates are comfortable, glare and reflection in the dining room is eliminated, lighting is good, and tray and bibs are used only as appropriate and with discretion. When the dining experience is not pleasant residents may blame the quality of the food rather than the cause of the problem.

Residents should be able to choose where they would like to sit whenever this is feasible and a floor plan should be used to show resident seating location which should be the type where the names can be changed conveniently without having the floor plan looking untidy. Diet cards and name tapes should not be put on the tables.

Staff can take the opportunity to sit with the residents at mealtimes and encourage conversation. This will help to stimulate a "family" type atmosphere and will assist residents to maintain their social skills.

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31 For additional information on dining facilities, see pp. 79 to 80.

8.6 Education Programs

Education programs in a long term care facility should be planned for residents, staff and all other individuals who interact with the facility. At the broadest level, information concerning the facility's goals, programs and services, and levels of care offered should be made known to the community.

Additional information that should be made available to educators and students in training would include explanations of the nature of disabilities leading to the need for care, and the various therapeutic services available for treatment. Education and training directed specifically to staff has been addressed in pages 33 to 77, and has also been referred to in each of the services outlined where appropriate.

Resident Education Programs

Because long term care spans all age groups and many medical conditions there will be great degree of diversity of educational requirements within the overall long term care sector. The educational requirements and capabilities of residents should be assessed on admission and incorporated into the care plan. They should be reassessed on a regular basis to plan for changing needs and to ensure that the best use is made of available resources in the community.

Younger residents may require access to schools and colleges and some may still be involved in the regular education system. Linkages with the individual's career development path should be maintained as far as his/her medical condition will permit. Individuals who require a career change because of a disability, may need an extensive educational program as a component of treatment. Each long term care facility will need to work with appropriate educational institutions to develop an overall care plan which addresses the total needs of the individual. Transportation, the need for personal

care and other factors will also affect the capability of the educational system to help specific residents.

Enrichment of an individual's life through taking a variety of courses within the post-secondary system has become popular with the elderly. Increasingly, educational institutions are providing specially developed courses and programs for seniors and in some communities these courses are given in space provided by the long term care facility. This encourages residents to participate and improves links with the community.

The skills of residents should not be overlooked. If a resident has special skills in a certain subject, it may be possible for the individual to teach other residents or other persons in the community. For example, a person with teaching experience may wish to offer these skills to children in the community who could come to the centre for remedial help. A carpenter may be able to advise and/or assist the occupational therapist with therapy using woodwork.

8.7 Health Records

It is essential to maintain an accurate and concise health record for each resident. In keeping with regulations and legislation, as well as the policies of the facility, each facility should determine how best to ensure record keeping and storage.

The record provides a basis for professional assessment and a plan for care, as well as for education and research.

Documentation should include reason for admission, prognosis, assessment, treatment and care plan, and ongoing monitoring of results, as well as change of status. A single record should be developed and maintained by all disciplines involved in the care of the resident.

The record should have:

- terminology that is brief, concise, accurate, and in keeping with long term care needs;

- consistency in recording through the use of definitions and abbreviations that are acceptable to the facility and the health care field;

- recording done only by authorized persons;

- recording that is legible and meaningful as well as regular, with the frequency to be determined by policy and in keeping with provincial requirements.

The facility must maintain the confidentiality of the information contained in the health record to protect the privacy and rights of the individual. Active (and terminated) files should be maintained in a safe and secure area and be available to those so designated. The facility should have written policies and procedures regulating access, release of and transmittal of information in compliance with legislation. Release of information can only be made through written consent of the resident, the family, next-of-kin or legal guardian.

Contents of the health record

The health record should consist of, but should not be limited to, the following:

- resident identification data;

- pre-admission assessment and/or transfer information;

- medical history and assessment - pre-admission, post-admission, annual and when necessary;

- social history;

- physician's treatment orders;

- care plan;

- progress notes, using multi-disciplinary approach (e.g., physician, nursing, therapy, dietary, social workers, chaplain - this is not an exhaustive list);

- drug profile;

- treatment records;

- diagnostic reports (e.g., lab, X-ray);

- consultation reports;

- consent forms - as appropriate;

- waiver of responsibility - as appropriate;

- transfer, discharge summary report;

- autopsy report - if applicable.

Storage of records

There should be a health record service responsible for the accurate process and storage of records, with consideration for fire, safety and security. A method is required for identification and storage of the record. Length of retention will be in conformity with legislation and the needs of the facility. Records should be readily available.

The size and nature of the facility or program will determine whether the service shall be the responsibility of a designated staff person or a health records department. A mechanism should be in place for reviewing the quality of recording with recommendations pertaining to forms and content of the record as related to the service required and desired.

8.8 Infection Control

In any institution, there is a need to guard against the occurrence of "nosocomial" infections. These are infections occurring in residents that are acquired as a result of living in the facility. Such infections could include influenza, food poisoning and urinary and vaginal infections. As most of the equipment, supplies and living space in the facility are shared by many residents, it is possible for an infection to rapidly spread throughout the facility if infection control procedures are not in place.

Residents are often admitted in a debilitated state with diminished resistance to infection. Others, because of their disabilities, are also vulnerable to infections. For example, decreased gastric acidity in elderly residents makes them more susceptible to acquiring gastro-enteric infections.

Infection Control Committee

As all staff have a part in controlling the spread of infection, the administration of the facility must devise a mechanism for infection control that will cover all departments, services and programs. This is best achieved by establishing an infection control committee and, where possible, by also appointing an infection control practitioner. The committee should have representatives covering all departments. It is imperative that medical staff support and be actively involved in the work of the committee. The committee should meet on a regular basis to review infections occurring in the facility, to advise on policies and procedures for infection control and to make recommendations regarding problems with infection control to administration, medical staff and other departments.

The facility should designate a staff member to assume responsibility for: monitoring the occurrence of infections in the facility; coordinating and monitoring the infection control program; and acting

as an information resource on infection control to staff, residents and families.

Policies and Procedures

Policies and procedures should be developed for prevention of infection and for treatment of residents/staff with infections. Protocols (guidelines) should follow provincial regulations and should be established for the areas such as isolation precautions and techniques, sterilization and disinfection, treatment procedures such as urinary catheterization, food handling, and waste disposal. The infection control committee should review the protocols annually and develop new protocols when necessary. Policies and procedures such as pre-admission and pre-employment screening of residents and staff will help to prevent food poisoning by food handlers who are carriers of salmonella.

8.9 Occupational Therapy and Physiotherapy

For the purposes of this document, Occupational Therapy and Physiotherapy are addressed collectively. These services may be combined where combined trained personnel are practising. However, it is more usual for professionals practising in these fields to be trained in one field only.

All residents have the right of access or referral to treatment as required to allow them to function at their optimum level regardless of disability.

Objectives of these services are:

- to prevent or minimize disability;
- to increase level of performance, functioning and communication;
- to promote social resettlement;
- to maintain current levels of functioning;

- to compensate for deficits by providing technical aids or assistive devices.

Organization

Depending on the type, size, function and location of facility, the provision of these services may be:

- in house departments - staffed by qualified and licensed therapists with assistance of aides under their supervision;

- purchased and shared services, such as consultant services on a contract basis with facility staff providing ongoing programs with in-service direction from the consultant as well as individual assessments and program design.

Treatment Plan

The treatment plan should be part of the total plan of care and should include assessment[32] diagnosis, goals and objectives in treatment, restrictions of treatment if any, and date of next evaluation.

Following assessment by the physiotherapist and/or occupational therapist, each therapist establishes a treatment and evaluation plan, which may include the following therapies (not listed in order of priority):

- training to return to maximum self care, which includes areas such as personal hygiene, dressing, and feeding;

- sensory stimulation and/or reality orientation to alleviate problems of confusion and disorientation;

- specialized exercise programs, such as those designed for limbs, and respiratory capacity;

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32 See also section on assessment, pp. 7 to 10.

- passive movements;

- self-help devices and specialized equipment;

- positioning for good body alignment;

- training to improve mode of transfer and ambulation;

- in conjunction with nursing, specialized treatment modalities, such as ultraviolet light, ultrasound and hydrotherapy.

To augment effectiveness of the therapeutic program the physiotherapist and/or occupational therapist may act as a resource to nursing, to activities and/or recreational services as well as to the family by:

- providing in-service orientation to staff and family regarding program and goals and objectives;

- assisting staff and family to "follow through" with client on training program initiated in therapy;

- setting up devices and/or adapted equipment so that the client may function more fully and efficiently.

Details of intended treatment intervention program must include:

- anticipated time frame for goal achievement where appropriate;

- involvement and responsibility of other members of the interdisciplinary team;

- devices or equipment required;

- need for facility's treatment to be supplemented by community resources and/or another centre.

The head(s) of physiotherapy and/or occupational therapy service must be qualified according to the

professional by-laws for practice as set by each national professional organization and/or by provincial governing bodies. Where in-house departments operate, the head(s) of service should be responsible for the administration of the service.

In-Service Education

Professional physiotherapy and occupational therapy staff should seek opportunities to provide in-service education for other staff and/or volunteers with whom they work. For example, provide education in areas such as proper methods of handling, lifts and transfers, feeding techniques, training in personal independence and reality orientation.

Physical Facilities & Equipment

(a) In house department - there must be provision of departmental space according to:

- size of population served;
- level of care;
- types of specialized programs. There must be provision of space for treatment on the unit when moving resident may be medically or mentally contraindicated.

(b) Consultant service - requires provision of space for:

- designated space and time to demonstrate and teach techniques to facility staff on a regular basis.

Equipment should be sufficient to provide appropriate programs to meet all resident treatment needs, and will be specified by the qualified therapists in each facility.

8.10 Orthotics and Prosthetics

Orthotic and/or prosthetic services are often required by persons receiving long term care. A prosthesis is an artificial limb or body part such as a leg, an arm, or an eye. An orthotic device is a biomechanical appliance applied to a body or limb to a) prevent deformities - e.g., splint or brace b) enhance use of the part or stabilize a part after surgery - e.g., corset, brace, spring loaded splint c) improve and enhance daily activity levels in independence e.g., seating system, feeding device.

Philosophy and Objectives:

Every amputee or orthotic patient should have access to specialized teams to explore the potential for improved and/or independent function. (see also Philosophy and Objectives pp. 53, 54).

Assessment and Planning:

An individual plan must be designed for each prosthetic/orthotic candidate with reference to medical, physical and psychological factors. Referral to a rehabilitation setting or to prosthetic and orthotic professional services, necessary for comprehensive assessment, is therefore advised; these services would not be part of the long term care facility.

Considerations necessary in planning for provision of and training with a prosthesis or orthosis should include resident's acceptance of the device and, expectations that the device will enhance cosmetic and body image as well as improve functional level. Provincial and/or individual funding systems may also be a limiting factor in selecting recipients for fitting and training.

Consideration must also be given to the physical layout, support services available, and staff experience and ability in the long term care facility in which the resident lives. Access to local or regional facilities, either institutional or private, should be

made available. Follow-up and training may be continued within the long term care facility using therapy staff with knowledge in prosthetic/orthotic techniques.

Following full assessment and prescriptions being established, the treatment plan will commence and will include pre-prosthetic and orthotic care, fabrication and fitting, training and follow-up.

Training and follow-up necessitates regular communication between technician, therapist and resident to ensure the successful use of a device which will become an intimate part of the wearer.

Qualifications

The prosthetist/orthotist must be certified and in good standing with the Canadian Board of Certification of Prosthetists and Orthotists.

Equipment

Equipment required for the fitting and alignment of the prosthesis/orthosis will be available in the specialized facility to which the resident is referred. Therapists in the long term care facility will be able, with minimal equipment, to make minor adjustments and repairs.

8.11 Palliative Care

Death and dying are accepted as part of life in the long term care facility. Staff are confronted daily with the needs of residents to talk about settling their affairs, making wills, their fear of dying or their wish to die. Physical pain, disfigurement, handicapping conditions and sometimes old age can lead to a diminished desire to continue living. Residents should be able to freely discuss death and dying without having their feelings denied by staff. The opportunity to discuss their fears with an empathetic person can help to reduce these fears.

It is therefore very important that all staff receive some orientation and training on how to cope with their own feelings regarding death and dying and how to respond to resident and family needs in this respect. Response to these needs will depend on the nature of the needs. However, it must be ensured that the resident is able to talk to a person who is comfortable in discussing the topic, perhaps a person with pastoral care training, a trained volunteer, or a staff member who has the skills for helping people in this respect. When a resident needs to talk, or to settle his/her affairs, the family should be informed and should be given staff support in dealing with a potentially stressful situation.

For the known terminally ill, there is a need for palliative care, that is:

> "Programs or services that provide care to those individuals for whom treatment aimed at cure and prolongation of life is no longer appropriate but for whom therapy aimed at improving the quality of the remaining life is the primary objective.
>
> Palliative care offers therapeutic services designed to address the physical, psychosocial and spiritual needs of dying patients and their families."[33]

The extent to which this type of care can be delivered in the long term care facility will depend on the nature of the illness, the medical intervention necessary for symptom control, and the ability of staff to deal with the increased workload. When a resident dies, it is important to ensure that other

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33 Palliative Care Services in Hospitals, Guidelines for Establishing Standards for Special Services in Hospitals, 1981. Health Services Directorate, Health Services and Promotion Branch, Department of National Health and Welfare.

residents and staff, who are part of the "family" of the deceased, are given the opportunity to pay their last respects to their friend. This can be accomplished by enabling the residents/staff to attend the funeral service or by having a memorial service in the facility.

8.12 Pharmacy Services

The purpose of pharmacy services is to provide medications to the resident in a safe and efficient manner and to promote rational drug therapy.

In the long term care facility, the practice of pharmacy has particular significance due to the chronicity of residents' conditions and multiplicity of drugs used. The residents' needs are best met by a resident oriented clinical pharmacy service in addition to an efficient distribution service.

A medication history should be obtained on all new residents and counselling should be given regarding medications in situations dictating need; e.g., self-administration, social leave. A medication review, of all medications and treatments, should be conducted on each resident, preferably monthly, or at least every three months. This review should be conducted on an interdisciplinary basis and should involve the pharmacist, nurse and physician.

The philosophy of the review is to ensure rational drug therapy using the minimum number of drugs. The objective is to assess, for each resident, each medication order for indication, efficacy, appropriate dosage and administration, appropriate laboratory and clinical parameters and length of therapy.

Organization

Pharmaceutical services may be provided from a variety of sources. While some long term care facilities have an organized pharmacy department with qualified personnel, there are alternative ways of providing pharmaceutical services. These include: a

shared service involving a number of facilities; contracting with an active treatment hospital; contracting with local pharmacies experienced in providing hospital pharmacy services.

Pharmacy and Therapeutics Committee

A Pharmacy and Therapeutics Committee, consisting of representatives of pharmacy, medicine, nursing, administration and others as necessary, should be organized and should meet at least every three months.

The Committee's duties should include:

- developing and maintaining a Formulary (where this is necessary);

- ensuring the general standards of pharmaceutical care of residents are met;

- formulating all policies and procedures dealing with drug utilization within the facility and putting them into a manual;

- formulating and implementing programs designed to provide staff with current knowledge of matters relating to drugs; and

- conducting drug utilization reviews within the facility.

Drug Handling, Procurement, and Distribution

Pharmacy services should be available 24 hours per day. The system for drug procurement should allow for prompt and efficient delivery of medications to the facility. A schedule for routine order and delivery should be developed and capability established for obtaining drugs after regular pharmacy hours; such as a "stat" box, or an "on call" service.

Medications brought into the facility with the resident should not be used unless in special circumstances where predefined written criteria are met; such as those ordered by the physician or a positive identification established with the manufacturer's lot number and expiry date available.

The aims of the system for drug distribution are accessibility, efficiency and safety. The controlled dosage system (30-day blister pack) best meets these criteria in the long term care setting. Unit dosage may be advantageous, although more costly, in certain settings. Individual prescriptions are an alternative. A total ward stock system should only be used if no other alternatives exist.

Medication Orders

Medications should be administered only on the order of a legally authorized prescriber (e.g., physician, dentist). Verbal orders for medication may be given only to a licensed nurse as governed by provincial legislation, a pharmacist, or a physician, and must be immediately recorded on the chart and signed by the person receiving the order. Such orders should be cosigned by the prescribing physician within 72 hours. Changes in medications should constitute a new order. Medication orders should be written on a multiple copy medication order form with the pharmacist receiving a direct copy of the medication order. Orders should be cancelled automatically when a resident is hospitalized for more than 24 hours, with new orders being required on readmission.

Prescribed drugs which may prove dangerous on prolonged use, such as narcotics, sedatives and hypnotics, antibiotics, mood-modifying drugs, anticoagulants and others, should be governed by an automatic stop order in accordance with a written policy.

In general, the use of standing orders is not recommended. When deemed necessary, they should be

written, dated and signed by the prescriber. For drugs which are ordered to be given as necessary, i.e. P.R.N. orders, the order should indicate the minimum interval of time between doses, the maximum number of doses to be administered in a specified time period, and the specific conditions for which the drug is to be given.

Medication Preparation and Administration

Medications must be administered in accordance with the laws of the Province. An individual medication record should be maintained for each resident. At the time the medication is administered, appropriate notation should be made on the medication record. This would include date, person administering medication, as well as refusals or not administered. The person preparing and administering the medication is responsible for documentation of administration.

Medications prescribed for one resident must not be administered to another resident.

Staff handling medications should have an up-to-date source of pharmacological and therapeutic information on all medications used.

A procedure for documentation and control of narcotic and control drugs must be developed in accordance with federal and provincial regulations.

Self-administration of medications should be permitted only on the written order of a physician. Policies should include reference to: counselling of the resident, accountability for administration, safe storage, packaging and re-order system.

Systems should be developed for handling and documenting medication errors. The physician should be notified of all medication errors immediately. The pharmacist should receive a copy of the incident form. The Pharmacy and Therapeutics Committee should review medication errors periodically with a

view to identifying causes and implementing corrective action.

A procedure for identification, handling and reporting of adverse drug reactions should be established, ensuring notification of the physician.

Emergency Drugs

An emergency drug kit should be maintained in the facility at all times to ensure life saving drugs are readily available in emergency situations. The contents of the kit should be determined by the Pharmacy and Therapeutics Committee, be clearly labelled, and carry a procedure for regular inspection by nursing and pharmacy.

Storage

Medications should be stored only in designated lockable medication storage areas and only authorized personnel should have access to these areas. A storage area capable of being locked within the lockable medication area is recommended for storage of narcotic and controlled drugs. Medications for each resident should be stored separately and external preparations should be stored separately from internal preparations. Drugs requiring cold storage should be stored in a refrigerator kept exclusively for that purpose. Drugs should be stored in their original containers.

A mechanism should be developed for ongoing removal of discontinued, expired, or unused drugs. Drug storage areas should be inspected at least monthly, to ensure proper storage procedures and removal of drugs. These should be returned to the provider pharmacy with the responsibility for disposal being that of the pharmacist.

Labelling

Labelling of the drug product should conform with provincial regulations, meet currently accepted

professional standards, and include any necessary cautionary statements as well as expiration date when applicable. Generic and appropriate accessory labels.

Any soiled or worn labels, makeshift and written over labels, should be returned to the pharmacist for proper disposition. Any changes should only be carried out by a pharmacist.

8.13 Psychology Services

The use of psychologists in long term care is a relatively new and emerging service. Psychologists have long been an integral part of mental health services for both adults and children. However, as services to the elderly have been developing, only recently has more attention been paid to how to care for mentally dysfunctioning elderly persons, the psychology and physiology of aging, and other issues which surround the treatment of adult disabled individuals.

Depending on their level of training and experience in the field, psychologists can provide assistance in long term adult institutional care in many ways such as clinical assessment, psychological testing, structured testing and neuropsychological assessment. Some psychologists have skills in counselling, and the design and application of behaviour management and/or techniques. Psychology staff can also contribute to staff education and can provide a consultative service to other treatment team members as they interact with the resident. Most psychologists have a strong background in research design and statistical methodology which is useful in the development of research programs related to either clinical practice or program evaluation.

8.14 Respiratory Technology

Respiratory technology should be available where medically indicated.

If respiratory therapy is required, this service should be handled by personnel formally trained for this purpose or by other personnel, such as a nurse, trained to give this therapy. If possible, the services of a Registered Respiratory Technologist should be available at least on a visiting basis to give training and maintain equipment.

The hygiene and safety standards regarding the use of these apparatus should be clearly defined and subject to continuous monitoring.

Built-in or portable medical gas should be available in facilities offering respiratory services, and be subject to storage standards and provincial fire codes.

8.15 Safety [34]

Safety is an important aspect of life in the long term care facility as many residents are handicapped by limitations such as poor mobility, vision, hearing, perception, and orientation. The maintenance of a safe environment is the responsibility of all persons associated with the facility from the architect designing the building to the volunteer helping with programs.

All long term care facilities should have an active safety program. Responsibility for developing, implementing and regularly monitoring this program should be assigned to one or more qualified persons. A safety committee with broad representation, including resident representation, is an effective mechanism for accomplishing this task. The main components of the safety program should include:

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[34] See Guide to Accreditation of Long Term Care Centres, Canadian Council on Hospital Accreditation, June 1978, for comprehensive coverage of this area.

- establishment, review and update of safety policies and procedures;

- review of accident and incident reports;

- review of reported potentially hazardous conditions;

- establishment of a preventive and corrective maintenance program;

- establishment of a staff and resident safety orientation and training program.

In each section of these guidelines, safety has been addressed where appropriate. Appendix VII, pages 115 to 121, describes certain aspects of safety in more detail.

8.16 Social Work

Attention to social needs is an essential element in the provision of long term care. Social work services are therefore an important part of the total plan of care and help residents and family members to use their own personal resources, institutional resources and community resources in a way that assists them to function at the best possible levels of health and well-being.

The scope of social work services will vary with the size, location, function of the facility, population served and the availability of community resources.

The nature of the social work service includes assessment of needs, interpretation of needs, referral to appropriate resources, orientation, crisis intervention and/or supportive intervention as required.

Organization

Social work services should be well organized and integrated with other services of the facility. By

contributing to the total plan of care, the social worker can take part in the treatment planning and possible discharge planning of the resident, in addition to providing counselling and support.

During the application phase the social worker can help to assess and counsel the individual and the family, and advise on possible alternatives and financial arrangements. Throughout the resident's stay at the facility, the social work services staff can provide support during the adjustment period and can contribute a social perspective to the total plan of care. Planning for discharge requires social work assessment and counselling in addition to support during the discharge period and follow-up after discharge.

The practice of social work in a long term care setting requires the identification and use of support services available to residents in the community. Social work service staff should use their knowledge to ensure a continuum of care for residents, and/or their families, from the point of initial contact to termination of social work services. The involvement with the community for purposes of resource identification and development of mutual education may be accomplished through liaison with community health and social agencies.

Staffing

Services may be provided by:

- An organized Social Work Service within the facility;

- A social worker(s) employed on a full or part-time basis;

- Consultant or contractual services obtained from the community, regional or provincial social services agencies, or other voluntary organizations;

- Other staff such as resident counsellors, or social work assistants, supervised by or in consultation with a qualified social worker.

8.17 Speech Pathology and Audiology

The elderly population displays a high incidence of hearing impairment and speech malfunction. Programs for communication disorders could greatly enhance the quality of life and social involvement of many residents. Additionally, aural rehabilitation programs, involving recognition of the link between speech disorders and hearing loss, should be developed. Procedures for prevention and early identification of communication disorders, including high risk registers, should also be established.

Organization

Following a medical assessment, if necessary, referral would be made to a speech pathologist and/or audiologist who would then make a clinical assessment.

An intervention plan would be established as part of the total plan of care, the plan would be implemented and follow-up procedures and an evaluation plan would be established.

Services may be available in the facility on a part-time basis, be seconded from a larger centre or be provided on a consultation basis. Residents in rural areas where services are often not available could be taken to a larger centre for evaluation and treatment prescription.

Staffing

Language-speech pathologists and audiologists require a university degree level of education with clinical training, including the specialized body of knowledge required to evaluate and treat individuals with communication disorders. They should also

possess adequate counselling and communication skills for working with the resident and the family.

Speech pathologists knowledgeable about neurogenic speech disorders and alternate/augmentative communication systems should be accessible.

Staff who do not have special qualifications in these fields should work closely with the clinicians trained in the field so that they can understand and continue to reinforce prescribed therapies on a day-to-day basis.

Other professional and technical staff that may also be involved include social workers, psychologists, electronic technicians and rehabilitation specialists.

Facilities and Equipment

Speech pathologists require a clinical setting to administer diagnostic tests and carry out intervention programs. Tools used in the diagnosis and treatment of speech disorders should be available or accessible.

Where audiology testing is carried out in the facility, a sound-proofed treatment room will be required.

The following basic audiology testing equipment will be required for hearing assessment in all facilities: Otoscope, tuning fork, aural speculum, and wax curette. Where an audiologist is carrying out more comprehensive testing in the facility, additional equipment may be required.[35]

For daily living, adaptive equipment may be required such as: amplified telephone, earphones for radio-t.v., visual alarm system, hearing aids, communication aids such as Bliss boards, and typewriters.

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35 See Guidelines for the Practice of Language-Speech Pathology and Audiology, Health Services Directorate, Health and Welfare Canada, 1982.

8.18 Spiritual Services

Religion can play an important part in the lives of long term care residents, and the facility has the responsibility of providing for their spiritual needs. Residents should be encouraged to maintain ties with their religious institutions in the community and attend services whenever possible. While formal arrangements for meeting spiritual needs are important, informal arrangements are also important. The wish to say grace before meals, and the need for quiet and privacy for prayer should be respected.

Where dietary restrictions are part of religious practices, staff should make every effort to accommodate these needs.

Organization

On admission to the facility, the resident and the family should be consulted with regard to their spiritual needs and preferences. Staff should then incorporate these needs into the care plan and make the necessary arrangements for required services.

Clergy from the community and lay visitors should be encouraged to visit their parishioners who are residents, to hold services in the facility and to contribute to the resident care plan where appropriate. In larger centres, a pastoral advisor with recognized qualifications may be appointed to coordinate the various spiritual activities in the facility. This person could help to ensure that residents have access to services/activities in their own religious denominations.

Provision should be made for a chapel to serve two basic functions to meet spiritual needs in the facility, these are the need to hold religious services and the need for quiet space for meditation and prayer for residents, families and staff. For everyday use, the chapel should remain small and intimate

but the facility should have the capacity to accommodate a larger religious service.

8.19 Support Services

Maintenance Services

A maintenance program for the facility should provide buildings, grounds, utility services and equipment with the continual care that is required in order to extend their life span and to provide a safe environment for residents and staff.

A planned maintenance program is necessary to ensure safety and quality of performance and to extend the serviceable life of buildings and equipment. Regular inspecting, testing and repairing of mechanical and electrical equipment are often required as part of safety code requirements. In addition, cost savings can be achieved if repairs are made before a piece of equipment breaks down. Evaluation of equipment can lead to identification of high maintenance costs and obsolete equipment/machinery.

Staff should be appropriately trained and either employed by the facility or be available to the facility on a consultant basis e.g., qualified engineer.

Laundry and Housekeeping Services

Laundry and housekeeping services should be organized in such a way that a safe, clean environment is provided for residents and staff. Provision must be made for appropriate equipment and adequate staff and supplies to properpy maintain these services.

Laundry services may be provided by staff employed by the facility in a central laundry or be contracted out either to a local hospital or a private company. There must be sufficient linen to ensure that demands for clean linen can be met.

The facility must arrange for residents' personal clothing to be laundered either by laundry staff or by residents where appropriate.

Soiled linen should be transported in a separate container from clean linen and infection control procedures should be followed when carrying out housekeeping and laundry services.[36]

8.20 Transportation [37]

Transportation services should be provided to allow residents to lead as normal a lifestyle as possible. These services enable disabled people to pursue educational, vocational, social and health related interests and assist them to integrate into the community. Provision of safe and adequate transportation is a significant step in alleviating barriers to achievement of their full potential as members of society.

The type of transportation services that a long term care facility would use would depend upon the needs of the residents, the degree of their disabilities, the intended purpose of the transportation services and the size of the facility. Attention must be given to the comfort, ease and dignity of the people using the system.

Following is a list of the more common types of vehicles which might be suitable for long term care facilities:

- specially equipped cars, vans or mini-buses

- taxis

- transit systems

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[36] See section on Infection Control, pp. 52 to 53.

[37] Additional information concerning legislation, organization of the service and equipment are contained in Appendix VIII, pp. 122 to 127.

- privately owned buses

- private cars.

These transportation services may be organized and operated by service clubs, municipalities, private individuals or businesses, the facility itself or any combination thereof.

8.21 Volunteers

Volunteers can contribute in many ways to the quality of life of the residents. They help to ensure that contact is maintained between the facility and the community. This helps residents to feel part of the larger community and may also serve to dispel myths about placement and long term care which compound the difficulties in adaptation that many residents experience. Volunteers can also help to maintain or restore morale, especially during the transitional phase after admission. By donating their time, talent and energy volunteers show the residents that people in the community care about them.

Volunteers can complement the services provided by the facility and staff in a variety of ways such as:

- helping with group activities e.g., crafts, education, music and therapeutic programs;

- accompanying residents on outings into the community;

- friendly and pastoral visiting, reading to residents, helping them to write letters and make phone calls;

- assisting and/or supervising a gift shop, snack bar, or library service.

Volunteers need assurance that the facility carries appropriate insurance so that they may feel free to

carry out their volunteer assignment without worry or concern for legal liability.

Organization

The coordination and direction of volunteer services should be delegated to a volunteer director who may be full or part-time. The director must be given responsibility for the total volunteer program including responsibility for supervising volunteer activities, maintaining coordination between volunteers and other departments and programs in the facility.

Volunteer activities and attendance should be recorded at the end of each session. Information recorded should be sufficiently detailed to provide a basis for periodic evaluation of the volunteer and the program.

Recruitment

Active and continuing recruitment is essential. A sufficient number of volunteers will prevent undue pressure from being placed on an individual volunteer or a group of volunteers and will permit volunteers to be placed where they will derive the greatest satisfaction.

Volunteers may be recruited from the community at large, from church groups, service groups, clubs, educational institutions, families and friends of residents as well as individual citizens. Staff members are frequently willing volunteers, some taking a special interest in a particular resident, while others help, when needed, at large social functions like special celebrations, events and outings. Residents, too, may offer their services on a voluntary basis.

Recruitment flourishes when potential volunteers are assured that there is a need for persons of all ages and that both male and female volunteers are

needed. They need to realize that volunteer contributions are purposeful and meaningful and offer an avenue to use their friendship, skills, knowledge and talent.

Selection and Placement

Criteria for selection of volunteers should be developed and should include personal attitudes[38], and suitability for specified tasks in terms of age, sex, socio-cultural background and education. Careful screening and placement will ensure that knowledge, skills and training are used to the best advantage. Specific tasks that can be filled by volunteers should be identified by volunteers, staff, and the volunteer director. A role description must be developed for each task and should include:

- a clear description of the activity;
- details of procedures required;
- responsibilities of the volunteer;
- location and duration of activity;
- equipment and supplies needed.

Orientation

An orientation schedule should be developed for volunteers[39].

Education

Volunteer education should be relevant, rewarding, informal and ongoing. It should provide volunteers

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[38] See also 7.1, p. 30.

[39] See Section 3, Appendix III, pp. 101 to 102.

with the appropriate information and training that they need. Volunteers can also take part in relevant in-service education sessions.

Recognition

Recognition of the contribution made by volunteers is essential. There must be a day-to-day recognition of the contribution that they make as well as more formal recognition such as an annual dinner and special awards.

9. SPACE ALLOCATION, UTILIZATION AND SPECIAL DESIGN FEATURES [40], [41]

9.1 Exterior

Although there are a number of factors which influence the choice of single rather than multi-storey buildings, a single level is preferable for evacuation in an emergency as well as for day-to-day programmes and resident use.

The site should permit easy access to the main and service entrances and allow sufficient space for the main driveway and walkways to extend to the main entrance so that residents can be easily picked up and returned to the facility. Consideration must also be given to providing convenient parking for staff and visitors.

The facility should be situated so that activity and dining areas receive some sunlight during the day, but not excessive glare and heat during the summer. A site that is free from gusty winds is

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40 Comprehensive guidelines for Design Consideration for Geriatric Care are being developed by Health Facilities Design Division, Health Services and Promotion Branch, Health and Welfare Canada.

41 See also Appendix VII Safety, pp. 115 to 121.

preferable with the building oriented so that the front entrance is away from the prevailing wind.

Access to the facility

To permit easy access to the long term care facility, the entrance should be provided with a direct and level route. A vestibule should be provided and the entrance should be filled with speed controlled automatic sliding doors. If electrically operated, they should have an emergency power service. Environmental conditions can affect their operation. A sheltered roof or canopy should be provided at the entrance. Depending on environmental conditions, consideration should be given to enclosed loading and unloading areas.

Where a change in level is absolutely necessary a ramp with handrails should be provided. All approaches to ramps, their deck surfaces and their landings require non-slip surfaces. Mechanisms should be incorporated that will keep the ramp free from ice. Curbs or low guard rails will assist in preventing wheelchairs from slipping off the end of the ramp.

9.2 Personal Space

The physical environment of the facility plays an important part in the quality of life for the resident. It is difficult, if not impossible, for a resident to be assured of privacy unless a facility has single rooms. Where sharing a room is unavoidable, steps should be taken to ensure that roommates are as compatible as possible. With so many group activities and experiences in a facility, space for solitude and reflection within independent reach of a resident's domain should be provided. Space for intimate meetings and exchanges should also be provided which should not be too far removed from the area(s) in which residents feel at home.

9.3 Recreation and Activity Space

Recreation and activity facilities should include sitting areas, and areas for exercising, games, entertainment, church services, reading or listening to music. A kitchenette, or an area with a kettle, coffeepot and provisions, where residents may prepare an unscheduled coffee or snack for themselves or their friends and family will help residents to retain a sense of independence. Residents should be encouraged to be responsible for its cleanliness and operation. Telephones should also be available for resident use in an area which affords privacy.

Gardens, lawns, patios, flowerbeds, barbecues and games equipment such as lawn croquet and horseshoes should be available for the residents. Gardens should have walkways, be appropriately fenced, located in an area protected from wind and be easily accessible to the facility. Areas suitably enclosed should be available for residents who are likely to wander away. Residents must be encouraged to continue their interests, for as long as possible. For example, an interest in bird-watching can be encouraged by means of bird feeders, bird baths and bird houses; for persons in wheelchairs gardening can be continued by means of raised flower boxes.

9.4 Dining Facilities

Pleasant dining facilities will enhance the enjoyment of the mealtime. Adequate space is needed for wheelchairs and parking of walking aids. The resident should be able to sit down at a table, socialize with others and enjoy their meal in a relaxed comfortable pleasant setting. There may be some occasions when a resident wishes to eat alone and this should be respected but not encouraged.

Dining room tables selected should accommodate wheelchairs so that the resident will not be seated too far away from the table as this contributes to discomfort tension and fatigue. It would be preferable, where possible, to have a resident who is in a

wheelchair transferred from the wheelchair to a regular chair.

The dining room should be well lit, bright, and open onto an attractive or interesting view if possible. The furnishings and decor chosen should be attractive and as homelike as possible. Glare from windows and reflection on floors and table tops should be controlled. Window glare can be controlled by use of curtains or drapes while reflection on table tops can be controlled with tablecloths. The floor coverings chosen should be the type that do not reflect light. Chrome and other shiny objects should be kept to a minimum in dining areas.

9.5 General Decor and Furnishings

Furnishings, floor coverings and wall decorations should not only be functional but should be appropriate for the age and cultural needs of the residents and should contribute to creating a warm homelike atmosphere. Residents and resident councils should be consulted when buildings are being planned, furnishing and art works are being chosen, and redecorating is being undertaken. Feelings of personal loss and of insecurity are commonly experienced when moving to a new home. Residents moving into a long term care facility must also cope with problems of adjusting to life in an institutional setting. Wherever possible, these residents should be allowed and encouraged to choose their own clothing and to bring some personal effects, such as an easy chair or a painting, to their new home. When they are able to use some personal belongings residents can better define their own territory and will be comforted by having familiar objects in an unfamiliar setting.

9.6 Lighting

Special lighting is required for a long term care facility to accomodate the special needs of the elderly who are the majority of the residents. The older

person not only needs higher quantities of illumination, but the designer must also plan good lighting design that ensures the quality of lighting provided by eliminating problems relating to brightness differences, discomfort glare, reflection factors and colour rendition. The aging process of the human eye results in considerable deterioration in visual ability including: ability to focus, rate of adaptation to different levels of illumination, resistance to glare and changes in colour perception. Two types of lighting are required: general lighting and task lighting. General lighting should enable furnishings and people to be distinguished, and should create a safe and pleasant environment. Task lighting provides a light source that can be directed toward a small area and is used for activities such as reading, writing, games and personal care.

For general lighting both fluorescent and incandescent light fixtures provide a good source of light when the type of fixture and its position are appropriately selected. The type of tube used in fluorescent fixtures should be carefully considered. Deluxe warm-white tubes cast a light which is complimentary to skin colour. The soft warm light of incandescent fixtures will help to give a familiar and home-like appearance in the facility. In service areas where high quality colour rendition is not important cool-white tubes would be acceptable.

Despite the decorative effects that can be achieved with pot lights, there are few locations where they can be recommended for use in a long term care setting.

The positioning of light fixtures and the careful arrangement of lighting fixtures can do much to eliminate unwanted and disturbing shadows. "Dancing shadows" can create an environment where unnecessary dependency is created, especially for confused residents and those with perceptual problems.

Flexibility in lighting is required in corridors, bedrooms, dining rooms and multipurpose areas. Dimmer switches for incandescent fixtures in these areas will provide flexibility and allow one fixture to be adapted for many purposes. An example is the use of a dimmer switch on a bedroom fixture, allowing that one fixture to serve as a night-light, as general lighting and as a task light. The use of dimmer switches encourages conservation of electrical energy and prolongs the life of the electrical bulb.

Exterior lighting can create a safe and welcoming environment at night for persons coming to and from the facility. Exterior lighting can help the facility to be easily identified from neighbouring buildings, ensure that walkways and entrances are clearly visible and create an interrelationship between the centre, the walkways and the parking areas. Good exterior lighting can also act as a deterrent to vandalism.

Exterior lighting can be both attractive and economical when a combination of incandescent and light intensity discharge lamps are used. Shadow control and the prevention of glare is also important. Exterior lighting may be turned on and off automatically.

For the convenience of visitors and emergency vehicles, the facility's name plate/sign should be well illuminated.

9.7 Colour

Well-chosen colour schemes provide a constant source of pleasure for residents, visitors and staff. People react to colour in individual ways according to their moods, past experience and individual preferences and, as previously stated the residents' preferences should be taken into consideration.

Colours play an important part in providing strong identification for specific areas. The use of colour coding may help residents realize where they are in the facility and may help to give them direction.[42] Colours that attract attention should be used as safety alerts and as accents to create an exciting and vibrant environment for activity and social areas. Colours that do not attract attention are preferred for areas where a restful or peaceful atmosphere needs to be created.

Many residents have visual handicaps, some of which can be reduced by the correct selection of colour and intensity. The lens yellows with age and older people see reds and warm colours more clearly than cool colours. However, this does not necessarily mean that they prefer warm colour over cool colours.

Ability to differentiate between blue and green declines rapidly with age due to the yellowing of the lens. Where it is important for a resident to be able to distinguish between blue and green, different intensities of these colours should be used.

Where residents may have difficulty in distinguishing between different surface levels the use of a contrasting colour of each surface is suggested:

- colour of table surface should contrast with colour of floor;

- colour of wall should contrast with colour of floor;

- colour of stair riser should contrast with colour of stair tread.

Glare from windows will appear less pronounced when the wall surrounding the window is light coloured. The colour of doors should contrast with the colour of the wall. In bedrooms, residents will be helped

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[42] See section on safety, pp. 115 to 116.

to differentiate the washroom door from the corridor door when they are painted different colours. Confused residents will be helped to locate washrooms in ancillary areas if washroom doors throughout the facility are the same colour.

9.8 Sound Control

An environment where sound level is maintained at a comfortable level will contribute to the quality of life for residents and visitors and to the efficiency of staff. Echos, reverberations, clatter and undesired background noises can be partially eliminated by architectural design, by controlling the time when sound producing equipment is used and by the use of sound-absorbing materials such as rough textures, pile, acoustic tile, soft drapery material and carpeting. Some of the resident rooms will need to be sound attenuated to reduce the disturbance that can be caused by confused or deaf residents who are sometimes noisy.

Although some areas need to be relatively quiet, the pleasant sounds of activity within the facility should not be totally screened out: the sound coming from lounges, multipurpose areas and dining rooms helps to give location clues to residents. However, if these areas become too noisy, some residents may prefer to remain in their rooms which could lead to social isolation. The indiscriminate use of radios, televisions and intercom systems should be avoided. A separate acoustically controlled area for piano and musical instruments is desirable.

Residents of long term care facilities have individual hearing needs. Where one resident needs a high level of volume to distinguish between sounds, another resident may find this same volume of sound irritating and painful. An awareness of these needs requires the provision of areas where different sound levels can be accommodated. Small lounges

can often be maintained as relatively quiet areas and can also provide privacy for meeting with family and friends.

10. EMERGENCY PLANNING

The governing authority must plan for emergency situations which could involve evacuation, relocation, survival and reception. The diagram[43] on page 86 shows emergencies that may occur and their potential impact on the community, the facility, the family and the individual.

A planning committee that addresses internal as well as external planning should be established. Internal membership would include the Administrator, a Medical representative, the Director of Resident Care, the Supervisor of Maintenance and/or Safety Officer and Department Heads and other staff as appropriate. External membership would include representatives from the Fire Department, Police, Ambulance Services, Public Health Department, Provincial Emergency Services and Social Services.

The responsibilities of the committee are: to develop emergency plans for disasters such as fires[44]; to ensure that all staff understand the plan and receive necessary training; to ensure that residents know the warning systems; to test the plan by conducting regular drills and exercises; and to evaluate and revise the plan as necessary. Emergency Welfare Services of the Department of National Health and

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43 Prepared by Emergency Welfare Services, Department of National Health and Welfare.

44 For additional information on fire safety, see pp. 118 to 121.
See also Manual for Fire Safety in Homes for the Elderly, National Research Council of Canada 1983, NRC 21249. Available from: Publication sales, National Research Council of Canada, Ottawa, Ontario, K1A 0R6. Price $9.

Welfare have developed an emergency planning manual for special care facilities.[45] The following extract from the manual illustrates the essential elements that need to be considered in developing a plan for emergency situations.

DISASTER

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[45] For additional information and the address of the regional office in each province, write or telephone: Emergency Services Division, Medical Services Branch, Dept. of National Health and Welfare, Ottawa, Ontario, K1A 0L3. Tel: (613) 996-2007.

Plan Content [46]

A. Organization

- Establish an Emergency Planning Committee.
- Prepare an organization chart defining emergency functions or emergency authority flow.
- List names and telephone numbers of key personnel.
- Establish liaison with the Municipal Planning authority and local Director of EWS.
- List names and telephone numbers of outside contacts (agencies, enterprises, volunteers).

B. Evacuation

- List circumstances under which evacuation may be required.
- List personnel having the authority to order a partial or total evacuation.
- Establish staff responsibilities.
- Establish methods of contacting key persons and staff.
- Establish internal traffic control.
- Establish method and priority of evacuation.
- Establish the vital records and documents to be part of the evacuation.
- Provide a clear and simple explanation of warning system.

In conjunction with the Municipal Emergency Planning authority:

- Establish evacuation routes, alternates and destination.
- Establish external traffic control.
- Establish the type and source of outside assistance required (fire department, police, etc).

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[46] Prepared by Emergency Welfare Services, Department of National Health and Welfare.

C. Relocation

- List circumstances under which relocation may be necessary.
- List personnel having authority to order relocation.
- Establish system to notify staff and key outside resources.
- Establish list of staff (and instructions) to accompany residents.
- List vital materials to be relocated (medical, clothing, food, etc.).
- Establish requirements at relocation site (food, bedding, clothing, etc.).
- Determine possible temporary release of selected residents and the procedures, location and contract.
- Establish feeding methods ("en route" and at relocation site).[47]
- Establish outside resources possibly required - addresses and telephone numbers.
- List place of relocation with alternates (internally and externally) and, if required, plan for utilization of a relocation centre.

D. Survival (isolation)

- List possible circumstances.
- List personnel with authority to implement survival procedures.
- List materials and equipment to be stockpiled and their storage location.
- Establish rotation system for perishable materials being stored.
- Establish area of building to be utilized for shelter from fallout if required.

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47 See handbook "Institutional Feeding in Emergency". Available from provincial Emergency Welfare Services organizations or Emergency Welfare Services Division, Department of National Health and Welfare, Ottawa.

- Establish minimum staff requirements.
- Establish emergency role of staff and residents.
- Establish the internal and external communication systems.
- Establish alternate arrangements for sources of water, light, heat, elevators, cooking, refrigeration, etc.[48]

E. Reception or expansion of services

- List authority for expansion or reception.
- Establish maximum potential for additional residents and staff.
- Establish possible temporary release procedures for some residents.
- Establish emergency role for staff, present and new.
- Establish system of identification and an emergency records system.
- Establish requirement of additional food, bedding and clothing.
- Establish emergency feeding methods.[48]
- In consultation with your Municipal Emergency Planning Committee:
  - Establish resources for food, bedding, clothing, other supplies and equipment.
  - List names and telephone numbers of suppliers.
  - Establish requirements for outside help (numbers as well as possible sources).

F. Co-ordination of plans

- Co-ordinate the institution's emergency plan with the community emergency plan.
- Co-ordinate the plan with other institutions.

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[48] See handbook "Institutional Feeding in Emergency". Available from provincial Emergency Welfare Services organizations or Emergency Welfare Services Division, Department of National Health and Welfare, Ottawa.

- Co-ordinate the plan with relocation facilities.
- Obtain agreements for outside resources.

G. Training

- Ensure the institutional staff's awareness of emergency plan.
- Keep residents informed.
- Exercise the emergency plan - establish frequency, system of monitoring, involvement with Municipal Emergency Services, and revisions.

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TYPES OF CARE [49]

The following types of care describe a spectrum of needs from some assistance and/or supervision to the full range of services available at an acute care hospital. **For the purposes of these guidelines Types II and III only are addressed.**

Type I Care

- is that required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition.

Type II Care

- is that required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who, having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24-hour basis, with medical and professional nursing supervision and provision for meeting psychosocial needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

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[49] As defined in The Report of the Working Party on Patient Care Classification to the Advisory Committee on Hospital Insurance and Diagnostic Services, November 1973.

Type III Care

- is that required by a person who is chronically ill and/or has a functional disability (physical or mental), whose acute phase of illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

Type IV Care

- is that required by a person with relatively stable disability such as congenital defect, post-traumatic deficits or the disabling sequelae of disease, which is unlikely to be resolved through convalescence or the normal healing process, who requires a specialized rehabilitative program to restore or improve functional ability. Adaptation to this impairment is an important part of the rehabilitation process. Emotional problems may be present and may require psychiatric treatment along with physical restoration. The intensity and duration of this type of care is dependent on the nature of the disability and the patient's progress, but maximum benefits usually can be expected within a period of several months.

Type V Care

- is that required by a person:

a) who presents a need for investigation, diagnosis or for definition of treatment requirements for a known, an unknown or potentially serious condition; and /or

b) who is critically, acutely or seriously ill (regardless of diagnosis) and whose vital processes may be in a precarious or unstable state; and/or

c) who is in the immediate recovery phase or who is convalescing following an accident, illness or injury and who requires a planned and controlled therapeutic and educational program of comparatively short duration.

BOARD SELECTION, STRUCTURE AND FUNCTIONS

1. Establishment of a Board

Selection

Board members may be either appointed or elected by the governing body and/or government agencies. Consideration should be given to the following dimensions when selecting new members:

- protecting and providing for the interests of the people they serve;
- meeting any unmet areas of expertise of the governing body (for example, financial management, fund-raising, technological advances);
- providing community and consumer representation;
- acquiring knowledge of the current programs and future plans of neighbouring associated health care organizations;
- ensuring that the interests of potential candidates do not conflict with the organization.

2. Term of Office

To ensure continuous input of new and innovative ideas, board members should serve for a definite term and a restriction should be made on the number of reappointments permitted. These principles are enforced in some provinces where legislation has been developed to limit the term of office and number of reappointments. In the absence of such legislation, the term of office should not exceed five years and no member should be allowed to serve for more than two terms without interruption.

Boards should be structured so that vacancies are staggered. This enables the board to maintain continuity in its operation and also bring in required expertise.

3. Size

Whereas a wide variance in the size of the governing body exists, the optimal size is considered to be in the range of 8-15 members. This size encourages active participation, allows for an appropriate committee structure and provides a base sufficient for consumer and community representation.

ORIENTATION PROGRAMS

Orientation programs should be provided for board members, staff and volunteers. Senior management and department heads must be committed to the development and delivery of these programs. While the following suggested programs are similar, each has special requirements.

1. Board Orientation

All new board members should receive an extensive orientation to the facility and its operation which should include:

- the purpose, objectives and goals of the facility;
- the nature of the long term care resident;
- tour of the facility;
- the provincial, municipal statutes and regulations, and by-laws of the facility which govern the facilities operation;
- organizational structure of the board;
- duties of the board, role and responsibilities of individual board members;
- source of funding;
- the role of government in long term care;
- the relationship of the facility to other community-based agencies, and health care providers in the community; and
- current issues in long term care.

2. Staff Orientation

An orientation program for staff consists of two phases, the general portion which all new staff members must attend and the departmental portion which is designed for all new staff members in each department.

Objectives of the general orientation section are:

- to familiarize all new staff with the philosophical concepts underlying the operation of the facility as well as the overall organization structure;

- to develop positive attitudes to the institutional team concept and where applicable to the multi-disciplinary team concept;

- to initiate an awareness of the staff members self-worth and contribution as a member of the team to the goals and objectives of the facility.

The general orientation should include the following topics:

Introduction - Welcome

- outline of orientation program;

Administrator - Welcome

- philosophy and objectives;

- ethical considerations;

- policies related to confidentiality and resident information;

- explanation of care program;

- the facility in relation to the community;

- team concept;

- personnel policies and procedures;

- fire and safety program;

- tour of facility and department.

It is useful to provide each new employee with a hand-out package which includes material for future reference. This packet could include such items as:

- personnel policies;

- employee information handbook.

Departmental Orientation

Each Department Head must develop a planned orientation program to the department, which should include the following:

- tour of department;

- introduction to co-workers and residents (where applicable);

- explanation of departmental organization and structure;

- review of departmental organization and structure;

- review of employee's job description.

3. Volunteer Orientation

An orientation program for volunteers should address the following components which should not be too cumbersome in detail:

- knowledge of the purpose, objectives and goals of the facility and an understanding of the policies that may affect them, especially fire and safety rules;

- tour of the facility;

- introduction to staff and residents with whom they will be working;

- explanation of their role as a volunteer and a clear understanding of how it contributes and melds with the assigned work of staff;

- orientation for staff to explain role and parameters of the volunteer contribution;

- familiarity, with cloakroom and changing facilities, and policies concerning out-of-pocket expenses, parking, code of dress, and mealtimes.

An orientation package could be developed and reviewed with each new volunteer who could then keep the package for reference when necessary. The orientation process should be documented by means of an orientation check list.

GUIDELINES FOR POLICIES AND PROCEDURES FOR SPECIAL SERVICES

Guidelines for policies and procedures for special services were formulated after a review of provincial, national and international information.

It is hoped that the following outline will serve as a guide for the development of more comprehensive and specific policies in order to ensure the most effective and efficient delivery of care.

I. ROLE AND OBJECTIVES

- Philosophy, role and objectives of the service
- Type of patients served
  - By diagnosis and/or severity of illness
  - Restriction of service, if any
- Services provided

II. ORGANIZATION OF SERVICE

- Governing Board responsibility
- Relationship to Administrator and Medical Staff
- Service management

(i) Specific responsibilities of staff

- Medical Director
- Other medical staff

- Nursing staff

- Other staff

(ii) Committees

- Membership to be defined by discipline and number

- Terms of reference to be defined

- Provision for consultation with appropriate staff members

- Schedules for formal and ad hoc meetings

III. POLICIES FOR OPERATION OF SERVICE

1. General

- Admission authority (Identification of individual(s) who have authority to admit)

- Admission priorities by:

  - Diagnostic category

  - Clinical condition

- Routine admission Standing Orders

- Medical Orders

- Emergency admission Standing Orders

- Length of stay by diagnosis

- Infection control and isolation

- Resident records, reports and charting

- Handling of emergency situations including C.P.R.

- Emergency delegation of responsibility to medical, nursing and/or other staff

- Research/Clinical investigation

- Palliative care, determination of death, authorization for autopsies, handling of bodies

- Referral, consultation (mandatory and other transfer, follow-up)

2. Staff

- Selection criteria: education, experience, interests

- Criteria for granting medical/clinical privileges

- Medical coverage/Staff coverage of service

- Delineation of student and supervisor roles including responsibility, authority and accountability

- Position descriptions

- Orientation and continuing education

- Performance evaluation

- Volunteers

3. Resident

- Residents' rights

- Resident identification

- Family participation

- Confidentiality

- Resident/family education
- Resident valuables, assets and belongings
- Consent for treatment
- Visiting privileges

4. Safety

- Safety and accident prevention
- Reporting of accidents and incidents
- Equipment maintenance and safety
- Fire and disaster plan
- Use of restraints

5. Quality Assurance

- Practice standards
- Continuing evaluation of effectiveness of service
- Resident status assessment on admission and discharge
- Incident reports
- Resident care review
- Infection control
- Audits: medical and nursing care, concurrent and retrospective
- Peer review
- Morbidity/mortality review

- Employee performance appraisal

- Product and equipment use and evaluation

IV. PROCEDURES

- Elective procedures

- Emergency alert system procedures

- Medical record and statistical procedures

- Policy and procedure manuals

EXAMPLES OF POLICY AND PROCEDURE MANUALS

The following is a list of suggested topics which should be developed and contained in the Administrative Policy and Procedure Manual. This list should be considered as examples of the core with additions being made in accordance with the needs of the organization.

- abuse
- administrative on-call arrangement and schedule
- admission policy
- affiliation agreements
- alcohol and non-prescribed drug use
- authorized charges to residents
- budgeting process
- capital equipment
- complaints
- consents
- deaths and autopsies
- discharge and transfer policy
- disaster plan
- disclosure of information
- donations and bequests
- fire safety and prevention program
- incident reporting
- information and communications
- insurance and liability coverage
- leaves of absence for residents
- missing residents
- personnel policies - hours of work, sick leave, vacation, uniforms, etc.
- petty cash
- purchasing policies and procedures
- record maintenance and disposal
- resident council
- residents' personal belongings
- separations policy
- smoking
- transportation
- trust accounts

- visiting hours
- volunteers.

The Departmental Manual

The departmental policy and procedure manual governs the operation of a particular service. This manual contains the policies and procedures which indicate the "how to" for that services and directs its day-to-day activities.

While the contents of the departmental manual will vary from service to service, each manual should:

- define the purpose and state the goals of the service;

- illustrate the organizational structure of the service demonstrating the authority, responsibility and accountability for individuals;

- describe the relationship of the service to other services within the organization;

- provide detailed instruction for the functions of the service;

- contain the personnel policies specific to the service;

- communicate the role of the service in fire safety and prevention and disaster planning;

- contain the work schedules for the various jobs within the service;

- include job descriptions for the various job classifications of the service.

The following list of contents for a Nursing Manual is intended to serve as an example of a departmental manual. This list is not comprehensive and would not be applicable to other services.

- Admission procedures

- Discharge procedures

- Incident reports

- Leave of absence

- Death as determined by the individual facility and in accordance with provincial regulations.

- Emergencies
  - accidents
  - fire
  - critical illness
  - maintenance problems with equipment
  - resident leaving facility
  - theft

- Physician's Orders
  - telephone orders
  - written orders
  - transcribing of doctor's orders

- Medication Policies
  - administration
  - transcribing medication orders
  - storage of drugs
  - disposal
  - drugs for "on leave" residents
  - emergency drugs
  - charting
  - drug errors
  - ordering of drugs not included in drug formulary
  - role of the pharmacist
  - role of the physician
  - Pharmacy and Therapeutics Committee
  - narcotics
  - self medication

- Restorative Care
  - procedures for encouraging independence
  - ambulation - gait training, care to weak limbs
  - bladder and bowel training

- Nourishment
  - food and fluid intake

- Safety and Restraints
  - philosophy
  - definition of chemical and mechanical restraints
  - alternatives to the use of restraints
  - rationale
  - types approved by Medical Director
  - assessment by the health care team
  - a review of physician's orders
  - an emergency standing order

- Transfers

- Additional Topics Suggested
  - personal grooming: skin care, hair care, finger and nail care, peri care, oral care
  - bed making procedures
  - isolation technique
  - transfer techniques - bed to wheelchair, etc.

RECREATIONAL ACTIVITIES AND PROGRAMS

The following list of possible activities for the residents offers suggestions only. It is not all-inclusive.

Audio-Visual Programs: Local libraries can provide films, slides, talking books, and video tapes, to meet special interests and needs. Investigate the libraries and audio-visual materials available from local industries, educational facilities and service clubs where applicable;

Baking and Cooking of Meals: for sales or small social group events;

Community Facilities: (with access for ambulation aids and wheelchairs) such as theatres, churches, libraries, community clubs and/or lodges may enhance and "normalize" institutional living by ensuring time and space to meet residents' special needs;

Crafts: geared to utilize talents and skills, provide an opportunity for creative expression and increase the resident's sense of self worth. These may be graded and designed according to interest, strength, finger dexterity and sight of residents;

Cultural Clubs: local ethnic groups may assist and gain from residents' background additional input to the language and cultural heritage;

Discussion Groups: for example current affairs, politics, past events, early life experiences, and present life style;

Drama & Theatre: like music and worship may make use of ethnocultural and religious backgrounds and include not only "performers" but many others in backstage supportive roles;

Games: such as adapted bowling, shuffleboard, table games, and floor checkers. Many of these games may lend themselves to "leagues" for continuity and goal orientation;

Horticulture: indoor and outdoor gardening with adapted and wheelchair height boxes where necessary;

Keep Fit: may be graded to include both ambulant and non-ambulant residents, such as simple exercises maintaining general range of movement of limbs, trunk and head, as well as encouragement of maximum use of their respiratory capacity. These exercises can be accompanied by singing and instrumental music which can add a further dimension to this activity's benefits;

Library Services: Library services, with particular emphasis on audio-visual aids should be available for the large number of residents who have sensory impairment, especially of vision and hearing;

Luncheon Group: to maintain and stimulate socialization skills. Depending on the season, mealtime get-togethers may be in the form of a barbeque or picnic, or outing to local restaurant or special event, such as a town fair (family members may enjoy being included in these activities);

Music: for listening, keep fit, dancing, entertainment, participation and encouragement of communication and development of latent abilities. (Music may be geared according to various age and ethnocultural groups and may be modified to allow for wheelchair dancing or varied styles);

Newsletter: which can be used as an outlet for free expression and can encourage wide levels of participation;

Pub Activities: give rise to informal relaxed socialization and maintenance of an earlier enjoyed life style;

Reading: should include the use of local library facilities for foreign language, travel, and large print books, "talking books" as well as catalogues;

Resident Activity Planning Forum: can exercise residents' leadership skills and can promote resident involvement in planning group activities;

Spectators: can be accomodated and welcomed. They should be able to watch with dignity those activities in which they can no longer participate;

Worship: with resident participation and inclusion. Musical and ethnic backgrounds become an integral part of fulfilling spiritual requirements of the residents and open opportunities for study groups.

SAFETY

In addition to the Canadian Council on Hospital Accreditation's guidelines for Environmental Services and Control[50], the working group identified the following safety-related areas.

1. Elevators [51]

Elevators used by residents should be equipped with special devices to accommodate persons with problems such as poor vision, hearing impairments, poor mobility and disorientation problems. Imprinted letters and figures on the buttons should be clear and large in size, and raised letters or braille could also be used to assist blind persons. The floor number should be clearly indicated on the sides of the door opening on each floor, or on the wall across from the door so as to allow the resident to see it clearly while standing inside the elevator. In some cases different colour codes are used on every floor to indicate the level. It is essential to have an arrow on every floor near the press button or above the door which clearly indicates to the waiting resident whether the elevator is going up or down. For the hard of hearing, interior panels with lights indicating the floor level of every stop should be clearly visible.

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[50] Comprehensive coverage of safety-related considerations is contained in the Guide to Accreditation of Long Term Care Centres, Canadian Council on Hospital Accreditation, June 1983, pp. 47-53.

[51] For other safety features, see design guidelines for Geriatric Units in Hospitals 1984, prepared by the Health Facilities Design Division, Health Services and Promotion Branch, Department of National Health and Welfare.

Elevator operating buttons should be at wheelchair height. The door opening timing should be adjusted to give enough time to the person with decreased mobility to get out of the elevator without being caught by closing doors. Handrails should be installed on the three sides of the elevator cabin.

For the person with disorientation problems, apart from the colour codes and the light panels, a voice system that tells the next floor stop, and whether the elevator is going up or down has been successfully used in some facilities. Elevator doors should have alert systems for wanderers who, for safety purposes, should be prevented from using the elevators unaccompanied. The identification devices previously suggested for outside doors could be used.[52] The alert should either indicate to the floor supervisor that the elevator is being used, or the system should be able to neutralize the activations of the elevator systems for persons wearing the identification devices.

2. Heating and Ventilation

Due to the various comfort levels of residents, it is advisable whenever possible, that each room have a temperature control by its own thermostat, and that the thermostat should be the enclosed type, key operated without any thermometers.

CMHC heating requirements state that "the system should be capable of maintaining a temperature of 24° C at a height of 150 mm from the floor. At 750 mm above the floor level, the temperature variation

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52 Mechanical Design Considerations for Special Care Units, Health Facilities Design Division, Health Services and Promotion Branch, Department of National Health and Welfare.

should not exceed 2° C. Despite the extra cost, the installation of a system to maintain a relative humidity of at least 25° is very desirable."[53]

Various mechanical heating and ventilation systems should be considered at the planning stage of new construction e.g., forced air systems, radiant heating, hot-water convection. Induction units and steam should not be used as any part of the direct heating systems in long-term care facilities.[53]

For the residents comfort and safety, ventilation and air-conditioning[53] should be provided at the following rates:

- residents' rooms: up to 4 air changes per hour;

- bathrooms and washrooms; up to 10 air changes per hour;

- waiting and living room areas: 4 air changes per hour if cigarette smoking is permitted.

The craft room and other rooms for special functions should have provision for a special exhaust system if woodworking equipment is installed and/or toxic substances are used.

3. Hot Water

Hot water for general use from the central or local system should not exceed 45° C (110°F) and precautions should be taken to prevent a build up of higher water temperature in piping systems during low or no use periods. All mixing valves in the baths or showers used by the residents should have

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53 Mechanical Design Considerations for Special Care Units Health Facilities Design Division, Health Services and Promotion Branch, Department of National Health and Welfare.

a built-in high temperature limit device set at 40° C (104° F) to protect the residents from scalding. Control devices should be inaccessible to residents and to the general public.

4. Fire Safety

Fire, and particularly smoke, presents a greater hazard to the residents of long term care facilities than in most other health facilities because of the relative dependence of the occupants. Administration and staff must study, identify and provide all necessary measures to ensure protection of the lives of all residents and users of services.

A reliable and effective, electrically-supervised, non-coded fire detection and alarm system must be provided so that prompt forewarning during the incipient stage of a fire will provide a real chance of survival for persons who could not escape the danger unaided. The system should comply with the requirements of the current Canadian Electrical Code.

Four major components of the fire safety system that are important to consider for safety purposes are: the detection devices; the alarm devices; the immediate primary control devices; and the evacuation procedures.

4.1 Detection

Special attention should be given to the location of detecting devices.

Ionization type, smoke detectors should be installed in the residents' rooms, corridors, physical and occupational therapy areas, chapel, recreation and dining areas. All remaining areas such as administrative, utility, janitors' closets, barber, beautician, kitchen etc., may be provided with either rate-of-rise heat detectors or sprinklers.

4.2 Alarm

In addition to the automatic fire alarm sounded by the detecting devices, manual fire alarm stations should be installed near all exits. Audible devices used to sound alarms should be chimes which should be of sufficient volume to warn all staff wherever they may be located in the course of their duties.

The control and announcement panel which indicates the location of the alarm station should be installed in an approved place and all personnel should be familiar with the location and method of activating the alarm.

4.3 Immediate Primary Control Devices

If sprinklers are used in some areas in the facility, the sprinkler system should be connected to the fire alarm control panel through a waterflow or pressure switch so that when a sprinkler head is discharged, the fire alarm system will be activated.

4.4 Evacuation Procedures

Fire safety and evacuation is an important consideration in the planning of a facility when deciding about the architectural concept (vertical building versus a horizontal building). Whichever concept is used, follow-up measures have to be worked out, in cooperation with the user group, in order to facilitate safe evacuation from the facility. A variety of considerations such as use of ramps, emergency lighting in strategic locations, barrier free evacuation routes, and emergency communication systems will need to be addressed. Evacuation plans should not be thought of as purely administrative responsibilities, but should also involve other professionals such as the architects and engineers responsible for providing the means to facilitate the executing of these plans, whether it be at the planning stage of a new facility or at a redevelopment stage of an existing facility.

The following fire safety mechanisms should be in place:

- There must be regular fire drills for the staff for all shifts. A record of attendees should be kept and the staff should be informed of theresults and the response details should be recorded for further improvements of the evaluation plans.

- All staff must be trained to use fire extinguishers.

- Fire escape plans should be posted in visible locations.

- A layout of the building including floor plans must be readily available in case of fire.

- Inspections with attention to checking, servicing and maintenance of fire safety systems should be carried out regularly by qualified personnel.

- Fire protection mechanisms ensuring that proper fire extinguishers and hoses are in place and in current working order and that extinguishers are available for different types of fires, e.g. electrical.

- Complete fire prevention inspections should be made of the entire facility and property each month. Reports of these inspections should be made and filed with the administrator and supported by periodic inspections and written reports by local or provincial fire authorities. These inspections should review at least:

- exits;
- electrical power systems;
- medical gas storage if necessary;
- flammable liquids storage;
- housekeeping;
- maintenance shops;
- laundry;

- radiology department (including radiation levels and protection measures);
- pharmacy;
- laboratory;
- storage areas for equipment and residents' personal belongings;
- oxygen and combustible material storage locations;
- safety measures.

TRANSPORTATION SERVICES

LEGISLATION

A combination of federal, provincial and municipal regulations may affect transportation services. An Advisory Committee on Transportation of the Handicapped, formed by Transport Canada in 1979, is responsible for developing a policy for modes of transportation under federal jurisdiction. However, operation and regulation of urban transportation services, is a provincial and/or municipal responsibility.

The 1971 Motor Vehicle Safety Act sets standards for new vehicles at the point of manufacture. Once the vehicle has left the original manufacturer, safety regulation becomes a provincial responsibility. The Canadian Standards Association Committee on Motor Vehicles for Transportation of Physically Disabled Persons has developed safety standards for the operation of vehicles used in the transport of physically disabled people.[54] As well, some provinces are drafting safety legislation. Driver licensing, driver training and regulation of automobile insurance are also provincial responsibilities. It is recommended, therefore, that individuals interested in supplying transportation services for the disabled inquire within their provinces concerning relevant legislation, in addition to contacting appropriate federal departments.

Factors to consider when organizing a transportation service include:

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54 D409 Motor Vehicles for the Transportation of Physically Disabled Persons, Canadian Standards Association, 1984.

Criteria for usage - that is, what priority is to be given to requests for usage of the service. In general, requests can be categorized as being work related, medical, educational, or recreational/social in nature. Designated uses must first be evaluated before size of vehicle, amount of seating, type of equipment to accommodate the maximum disability, etc., can be determined.

Type of Service - Consideration should be given as to whether the service is to be used exclusively by the facility and/or be community-based. A public transit system with a demand-responsive capacity, e.g. "Dial-A-Bus", allows many people to share the system on a "as needed" basis. This provides sufficient flexibility to serve many of the needs of those in the long term care facility and enables the service providers to take advantage of provincial subsidies which are between 50 per cent to 75 per cent in most provinces. If the criteria for usage of parallel or private system is too narrow, in general, these systems often fail economically. If a service is offered which includes other users from the community, such as pregnant women or women with small children, other elderly and other disabled people in the community, encouragement will be present to offer a high caliber of service.

Leasing, contracted services, joint purchase and shared services could be considered as alternatives to single ownership. As well, the invaluable service that can be provided by the voluntary sector should not be overlooked. Should a facility decide to have transportation services provided by volunteers, a policy concerning liability should be developed to include adequate insurance coverage. Ambulance service should not be considered as a form of transportation for non-emergency situation, it is very costly and should be used only when medically necessary.

Cost - Available subsidies will have a bearing on the type of transportation service selected, particularly if the option of public transportation is being

considered. As well, an estimate of the average number of users occupying the vehicle at any one time must be considered when selecting the type of service required. An efficient scheduling plan is essential. Down time is an important factor. Also, the cost of storage, maintenance and insurance must be addressed. In selecting the size and type of vehicle required, consideration must be given to the amount of usable floor space available rather than the square footage. If a basic van is selected, prior to purchase, it is essential to ensure that the conversion plans can be accommodated.

Safety - The importance of having drivers who are properly trained and licensed cannot be overemphasized. Training should include demonstrated competence in first aid, as well as wheelchair safety, safe use of equipment such as wheelchair lifts and tie downs, techniques to assist residents with walking aids, emergency procedures and instructions in the interpersonal relationships and needs of the elderly and disabled. Policies and procedures concerning transportation services must be developed by the institution, and should include such areas as safe operation of the equipment, safety of the drivers, safe operation of the service, and insurance coverage.

Adequate public liability insurance is essential. As well, the facility's insurance program should be in compliance with provincial policies.

EQUIPMENT

The following specialized equipment must be provided in vehicles transporting the disabled:

- stabilizing devices for all wheelchairs and stretchers. Both tie down and clamp down systems are available, the latter one being the system of choice;

- seat belts for all passengers including wheelchair users. For modified vehicles, special attention must be given to the secure attachment of seat belts;

- appropriate grab-bars in passenger areas for support and safety;

- vehicle access devices. For safety and convenience, a lift is preferable to a ramp. Ramps, although less expensive, require strong drivers to transfer each wheelchair on and off the vehicle and may be limiting in terms of terrain. While there are several types of lifts available i.e., hydraulic and electric, a heavy duty lift which runs off an auxilliary battery is recommended. When selecting a particular type of lift, consideration must be given to the availability of local servicing. The lift, ideally should be on the right side towards the front of the vehicle, to facilitate loading and unloading and must have:

    1. A safety clutch or brake which will stop the lift in case of equipment failure, as well as an easily operated emergency manual system

    2. A platform with a safety edge on the sides and front, and broad enough to accommodate a wide adult wheelchair

    3. Two sets of controls - one on the outside of the vehicle and one on the inside

    4. A design such that it requires only one person to operate it

- a hand railing on the side of the lift is an optional feature. The person who has difficulty remaining in an upright position should be appropriately secured in the wheelchair. The inclusion of steps with handrails for ambulatory residents is useful;

- interior climate control system to maintain comfortable temperatures in the passenger area. A proper ventilation system is essential which would include windows which could be opened, if necessary. An auxiliary heater may be necessary to compensate for the large amount of heat lost each time the lift is operating. Good defrosting mechanisms such as window frost shields are recommended for increased visibility;

- adjustable padded head rests behind the seats;

- emergency equipment, including a fire extinguisher, flares, first aid kit, emergency phone list and any other equipment required by provincial legislation;

- a flexible seating system which accommodates open space for different size wheelchairs and which provides flip-up seats or fixed seats over wheel wells. Totally fixed seating is frequently impractical, requiring numerous transfers between wheelchairs and seats to load and unload the vehicle. These numerous transfers can be hazardous and inconvenient for both driver and passenger;

- additional interior lights to enable the vehicle to be used at night;

- flashing emergency lights on the vehicle;

- devices to secure doors in the open position during loading and unloading to prevent doors from closing accidently;

- floor covering that has good traction and is easily cleaned.

In addition to this essential equipment, the following options are recommended:

- for a van: a raised roof with an exhaust fan for good air exchange ventilation.

- some type of communication system, such as citizen's two way radio.

GUIDELINES FOR SPECIAL SERVICES

The following guidelines have been prepared by the federal-provincial Sub-Committee on Special Services in Hospitals. These guidelines were requested by the Federal-Provincial Advisory Committee on Institutional and Medical Care Services. Some of the guidelines are updated versions of guidelines previously published by the Sub-Committee.

Addiction Services
Adult Long Term Institutional Care
Adult Psychiatric Services Provided by General Hospitals
Burn Unit
Cardiovascular Services in Hospitals
- Ambulatory Electrocardiography Monitoring
- Cardiac Care
- Cardiac Catheterization
- Cardiac Surgery
- Cardiovascular Nuclear Medicine
- Cardiac Pacemaker
- Cardiac Stress Testing
- Echocardiography
- Intermediate Cardiac Care
- Non-Invasive Vascular Laboratories
- Phonocardiography

Child and Adolescent Psychiatric Services Provided by General Hospitals
Child and Adolescent Services in General Hospitals
Computed Tomography
Day Medicine
Day Surgery Unit
Dental Care Units in Hospitals
Diabetic Day Care Unit
Diagnostic Ultrasound Facilities in Hospitals
Emergency Services in Hospitals
Geriatric Day Hospitals
Geriatric Unit in a Hospital

Intensive Care Unit
Nuclear Medicine in Hospitals
Palliative Care Services in Hospitals
Patient Hostel Unit
Perinatal Intensive Care Unit
Regional Renal Failure Program
Rehabilitation Medicine Unit
Respiratory Technology Service/Unit
Spinal Cord Injury Unit
Stroke Services